

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 77-02023			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA A. ALEXEIEFF				JAN. 27 1977 9:45 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 16 1894		6. AGE (IN YEARS LAST BIRTHDAY) 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SILVIAN MANOR HEALTH CARE CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 11636 Lockwood Drive.	
14. FATHER'S NAME FIRST MIDDLE LAST Alexandr Segurirov				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. none		17. INFORMANT ADDRESS Mrs. Alla Pietsch- (same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC H. DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) PNEUMONIA, OSTEOPOROSIS							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (the hospital) attended the deceased from 2/30, 1973, to 1/27, 1977, that (we) lost s/he the deceased alive on 1/19, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Daniel Rosenthal MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/27/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM				22e. ADDRESS 10400 CONNECTICUT AVENUE KENSINGTON, MD 20745			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 29, 1977		23c. NAME OF CEMETERY OR CREMATORY Kings Highway		23d. LOCATION CITY OR TOWN COUNTY STATE Milford Connecticut	
24. FUNERAL DIRECTOR'S NAME Warner E. Humphrey, Inc., 8434 Ga. Ave., S.S. Md.				25a. DATE REC'D. BY REGISTRAR JAN 31 1977		25b. REGISTRAR'S SIGNATURE Patrick McCready	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

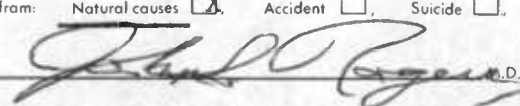

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 77-02024							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH	
FLORENCE ALLEN								MONTH DAY YEAR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
F		CAU		8 MONTH DAY YEAR		78 YRS		1 7 77 7.55 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		U.S.A.				Montg. County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Rockville		POTOMAC VALLEY N. HOME		Housewife					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Pennsylvania				Connellsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		None	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
C. Walter Erbeck		Emma Buttermore		No		Unknown		Leo Sullivan Rockville, Md. (Attorney)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4409 Generalized Arteriosclerosis						years			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a. I certify that (a) this person attended the deceased from		19 73		to Jan 7 19 77		that (we) last saw the deceased alive on 1 6 19 77		and that in (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death)	
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
JAMES W. EGAN						1/7/77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
JAMES W. EGAN		5413 Cedar Lane - Bethesda Md		Burial		1-11-77		Hill Grove Cemetery	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		23d. LOCATION CITY OR TOWN		COUNTY STATE	
Tyson Wheeler Funeral Home, Inc.		JAN 17 1977		Anthony McCready		Connellsville		Pennsylvania	
1331 Rockville Pike Rockville, Md. 20852									





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
30M 7/73

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 77-02025			
1. DECEASED NAME (TYPE OR PRINT)		FIRST GEORGE		MIDDLE C.		LAST APOSTOLIDES						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 1/6 1977		2b. HOUR M 3:00 A. M.	
3. SEX M.		4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR 5 15 97		6. AGE IN YEARS (LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1/6 1977		7d. HOUR A. M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1955 Seminary Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Taxi driver				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1955 Seminary Road					
14. FATHER'S NAME FIRST MIDDLE LAST Apostolos Apostolides						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Mitsari									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-01-7060		17. INFORMANT ADDRESS Penelope Apostolides, see item #13									
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1978 IMMEDIATE CAUSE (a) Carcinoma of the liver. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). None															
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) None							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE 				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER 1919 Seminary Road				DATE SIGNED 1/6/77			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.				ADDRESS Silver Spring, Montgomery, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial				23b. DATE 1/8/77		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland					
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR JAN 11 1977		25b. REGISTRAR'S SIGNATURE 							

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02026

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FANNIE D. APPLER			2a. DATE OF DEATH MONTH DAY YEAR 1-29-77		2b. HOUR 2 <sup>10</sup> AM
3 SEX FEMALE	4 RACE W	5. DATE OF BIRTH MONTH DAY YEAR 9 26 86		6 AGE (IN YEARS LAST BIRTHDAY) 90 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10 CITY OR TOWN OF DEATH SILVER SPRING	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHEVY CHASE NURSING CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE MARYLAND	13b. COUNTY MONTGOMERY	13c. CITY OR TOWN SILVER SPRING	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 207 GRANVILLE DRIVE	
14 FATHER'S NAME FIRST MIDDLE LAST JOHN DOUGLAS DENNIS			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZA ELLEN FEWELL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 59-46-7789 A		17 INFORMANT ADDRESS CLARENCE C. APPLER SAME AS 13 SON	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Heart Disease</u> NOS 104x (c) <u>Generalized arteriosclerosis</u> NOS 104x		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 4</u> 19 <u>77</u> to <u>1/29</u> 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>1/23</u> 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Albert H. Grollman</u> MD		22c. DATE SIGNED <u>1/29/77</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ALBERT H. GROLLMAN</u>		22e. ADDRESS <u>1106 SPRING ST. SILVER SPRING MD.</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/31/77	23c. NAME OF CEMETERY OR CREMATORY GEORGE WASHINGTON	23d. LOCATION CITY OR TOWN COUNTY STATE HYATTSVILLE PRI GEO MD.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR FEB 3 1977	25b. REGISTRAR'S SIGNATURE <u>Henry McLean</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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15-02113



JOHN DOUGLAS EDITH EDITH EDITH EDITH

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#5 8503 1/26/77 83

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH J.C.77-02027  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>MILDRED T. BANKS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-15-77</b>			2b. HOUR <b>11:30 PM</b>			
3. SEX <b>FEMALE</b>		4 RACE <b>CAUCASIAN</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>AUG 12, 1914</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>62</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY County MD.</b>			
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>HOME</b>			
13a STATE <b>N. CAROLINA</b>		13b COUNTY <b>CRAVEN</b>		13c CITY OR TOWN <b>NEW BERN</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>2107 SPENCER AVENUE</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>THURMAN F. TYSON SR.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE <b>RUTH KING</b>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					
16b SOCIAL SECURITY NO. <b>NOT AVAILABLE</b>		17 INFORMANT <b>ROBERT M. TYSON</b>							
16c ADDRESS <b>1308 HERITAGE DRIVE</b>		<b>NEW BERN, N.C.</b>							

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Renal Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
203X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple Myeloma</b>	
		DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Severe Anemia</b>			

19a DATE OF OPERATION <b>—</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (the hospital) attended the deceased from <b>12/30</b> , 19 <b>76</b> , to <b>1/15</b> , 19 <b>77</b> , that (I) <del>last</del> saw the deceased alive on <b>1/15</b> , 19 <b>77</b> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did not</del> (did not) view the body after death.							
22b SIGNATURE <b>Augustus B. Aquino M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <b>1/16/77</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Augustus B. Aquino</b>		22e ADDRESS <b>10401 Old Georgetown Road Bethesda, Md. 20014</b>					

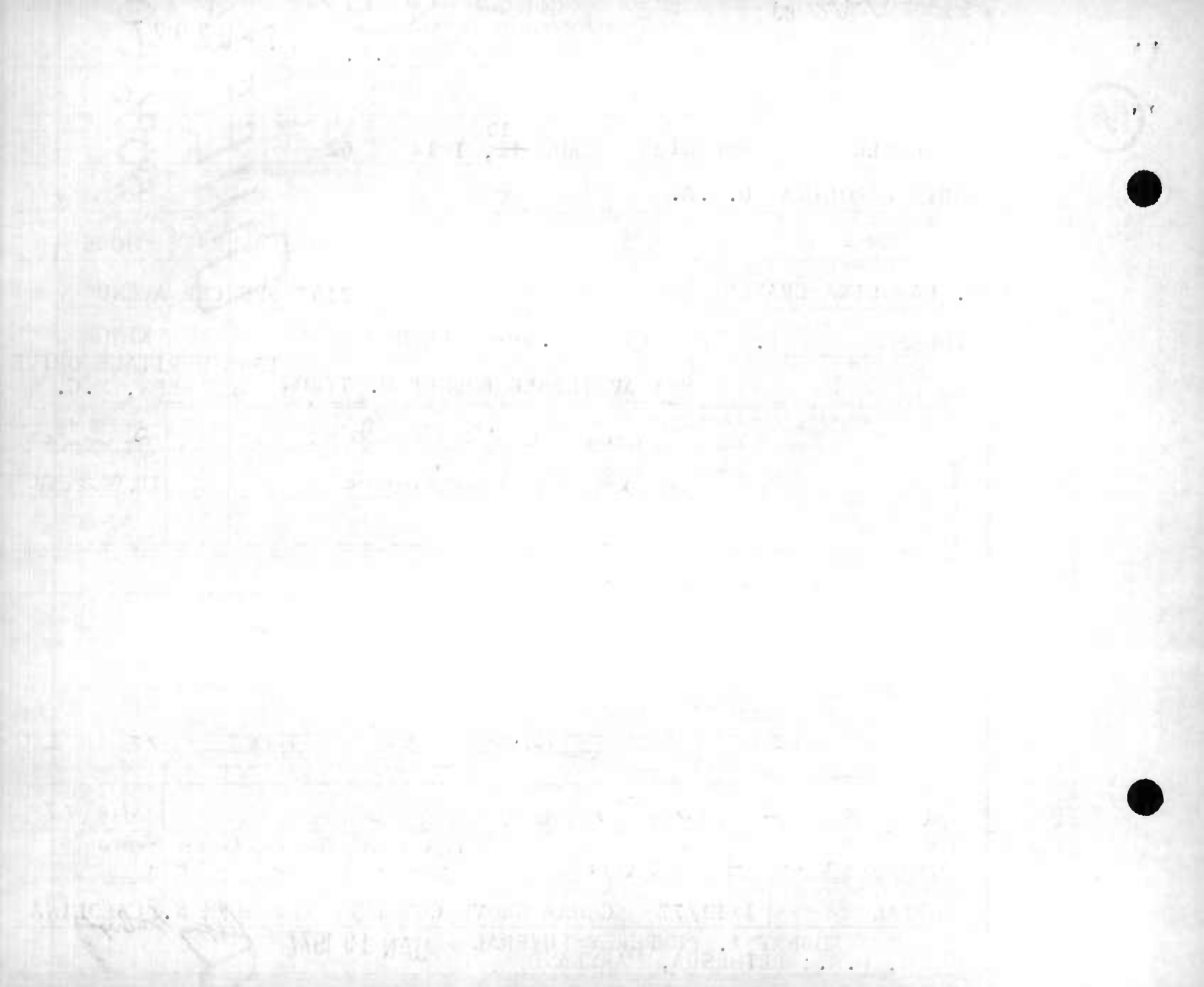
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>1/19/77</b>		23c NAME OF CEMETERY OR CREMATORY <b>CEDAR GROVE CEMETERY</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>NEW BERN N. CAROLINA</b>	
24 FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A.; BETHESDA, MARYLAND</b>				25 DATE RECEIVED BY REGISTRAR <b>JAN 19 1977</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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2101  
 cleared by Dr. Rogers 9/18/77 1/30/77  
 TO HOSPITAL OR ATTENDING PHYSICIAN. This law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

DHMH - 16 60M 1/75  
 (VR A 15 (4))

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					77-02028 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Mary Barbera</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>01 30 77</b>			2b. HOUR <b>9:10A</b> M	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10 06 02</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Montgomery</b> 13c CITY OR TOWN <b>Silver Spring</b>					13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>330 University Boulevard, E</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Petrio Carollo</b>					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lucille Carollo</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>212-74-4281</b>		17 INFORMANT <b>Daughter</b> ADDRESS <b>Grace L. Staten, 17, 505 Lisa Drive, Derwood, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY <b>4109</b> IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Dis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>12 hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>06 30 hrs 30 Jan 19 77</b> to <b>09 10 hrs 30 Jan 19 77</b> that (I) (we) last saw the deceased alive on <b>30 Jan 19 77</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) and did not view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN I. KERMAIER, MD</b>				22c. DATE SIGNED <b>30 Jan 77</b>				22d. ADDRESS <b>9801 GEORGIA AVE. S.S., MD 20902</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/2/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont Md.</b>		23e. DATE RECEIVED BY REGISTRAR <b>FEB 3 1977</b>	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>					25a. DATE RECEIVED BY REGISTRAR <b>FEB 3 1977</b>				
500 Univ. Blvd., W., Silver Spring, Md. 20901					25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>				



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02029

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>KYLE D. BARNES</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-7-77</b>			2b. HOUR <b>7P</b> M			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11-11-17</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MISS.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Foreign Service Officer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>MONT.</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1121 UNIV. BLVD., W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ORDA ESTII BARNES</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LUDIE TAYLOR</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WW II 577-05-9290</b>			17. INFORMANT ADDRESS <b>MARCELLA R. BARNES SAME AS 13 WIFE</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1621 MALNUTRITION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>EPIDERMAL CARCINOMA, LEFT HAND</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>1 yr.</b> <b>13 mths</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>NONE</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>DECEMBER 1, 1975</b> to <b>JAN 7, 1977</b> , that (1) (we) lost saw the deceased alive on <b>1-7-77</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death.)									
22b. SIGNATURE <b>John B. Nason, MD</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-7-77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN B. NASON, MD</b>			22e. ADDRESS <b>800 BERSHING DR. SILVER SPRING</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/10/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON, D. C.</b>		
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick McCready</b>	

MEDICAL CERTIFICATION

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KYLE D. 11-17-79

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U.S.A.

Director, Federal Bureau of Investigation

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 77-02030			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
GRACE I BARR				1 13 77 12 15 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		Oct. 3 1886		90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
D.C.		U.S.A.				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Kensington		Kensington Garden's Nursing Home		Personnel Clerk (Ret) Dept.		Justice Dept.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. STREET ADDRESS			
D.C.		Washington		5801 New Hampshire Ave., N.W.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Charles Mallard				Annie O'Neill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		579-60-8656		Son Edward F Barr,		8207 Meadowbrook Lane, Chevy Chase, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
4339 IMMEDIATE CAUSE (a) Terminal Cerebral Thrombosis							
DUE TO, OR AS A CONSEQUENCE OF (b) —							
DUE TO, OR AS A CONSEQUENCE OF (c) —							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH AND NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/29/76, to 1/13/77, that (I) (we) last saw the deceased alive on 1/12/77, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
				MD ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/13/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
OSOTH LEKAGUL, MD				8218 Wisconsin Ave., Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		1/15/1977		Ft. Lincoln Cemetery		Brentwood, Md.	
24. FUNERAL DIRECTOR NAME				25. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
JOSEPH GAWLER'S SONS INC.				JAN 24 1977			
1830 WIS. AVE., N. W. WASH., D. C. 20006							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02031 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Charlie Nelms Barron Sr.</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>January 7, 1977</b>				2b. HOUR MIN. AM <b>11:11 A</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 8, 1922</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7d. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinical Center, NIH, Beth. Md</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>VETERINARIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>VETERINARIAN</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>FREDERICK</b>		13c. CITY OR TOWN <b>Mt. Airy</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Box 216 R.D. 2</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Tom JOE - Barron</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie LILLIAN - Robinson</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			
16b. SOCIAL SECURITY NO. <b>1943-46</b>				16c. SOCIAL SECURITY NO. <b>449-28-9614</b>				17 INFORMANT <b>Medical Record Dept. Clinical Center, Bethesda, Md NIH</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: <b>2049</b> IMMEDIATE CAUSE (a) <b>Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Lympho Sarcoma Cell Leukemia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b> <b>1 Week</b> <b>3 Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (X) (this hospital) attended the deceased from <b>December 20, 1976</b> to <b>January 7, 1977</b> , that (X) (we) lost above the deceased alive on <b>January 7, 1977</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (We could not view the body after death.)											
22b. SIGNATURE <b>Neil M. Ellison MD</b> DEGREE						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/7/77</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Neil M. Ellison</b>						22e. ADDRESS <b>National Institutes Of Health Clinical Center, Bethesda, Md 20014</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>JAN 10-1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LINGANORE</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>UNIONVILLE MD</b>		23e. DATE REC'D. BY REGISTRAR <b>JAN 11 1977</b>			
24. FUNERAL DIRECTOR NAME <b>D. D. Hatcher, Libertytown</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1977</b>					

MEDICAL CERTIFICATION

BP

18050-81

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02032

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Herbert E. BASS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>January 20 1977</b>			2b HOUR <b>855P</b> M				
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 19, 1920</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U. S. Air Force</b>		12b KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>N.C.</b>			13b COUNTY <b>Chowan</b>		13c CITY OR TOWN <b>Edenton</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>Box 175</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Hubert Victor Bass</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Artimisa White</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b SOCIAL SECURITY NO. <b>WWII</b>		17 INFORMANT ADDRESS <b>Lola Allen Bass same as 13e</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
3960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Rheumatic aortic stenosis, rheumatic mitral stenosis</b>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Bronchopneumonia</b>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I (this hospital) attended the deceased from <b>Jan. 19</b> , 19 <b>77</b> , to <b>Jan. 20</b> , 19 <b>77</b> , that (I (we) last saw the deceased alive on <b>Jan. 20</b> , 19 <b>77</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>Judy E. Schwartz</i>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Jan. 21, 1977</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Judy E. Schwartz, M.D.</b>						22e. ADDRESS <b>National Naval Medical Center, Bethesda, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/23/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beaver Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Edenton, N.C.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert A. Pumphrey Funeral Home Bethesda, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1977</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>		

BP

January 20, 1977

Mr. J. Edgar Hoover

Washington, D.C.

U.S. Attorney General

Department of Justice

Washington, D.C.

Dear Mr. Hoover:

I am writing to you today

to inform you of the results

of my investigation into the

activities of the

Organization for a

Democratic Society.

The results of my

investigation are as follows:

1. The Organization for a

Democratic Society is a

legitimate organization

which is engaged in

political activities.

2. The Organization for a

Democratic Society is not

connected with the

Organization for a

Democratic Society.

3. The Organization for a

Democratic Society is not

engaged in any

illegal activities.

4. The Organization for a

Democratic Society is not

engaged in any

unlawful activities.

5. The Organization for a

Democratic Society is not

engaged in any

unlawful activities.

6. The Organization for a

Democratic Society is not

engaged in any

unlawful activities.

7. The Organization for a

Democratic Society is not

engaged in any

unlawful activities.

Very truly yours,

John Edgar Hoover

Director

Federal Bureau of Investigation

U.S. Department of Justice

Washington, D.C.

Enclosure

cc: Mr. Tolson

cc: Mr. Casper

cc: Mr. Callahan

cc: Mr. Conrad

cc: Mr. Felt

cc: Mr. Gale

cc: Mr. Rosen

cc: Mr. Sullivan

cc: Mr. Tavel

cc: Mr. Trotter

cc: Mr. Tele. Room

cc: Mr. Holmes

cc: Miss Gandy

cc: Mr. Nease

cc: Mr. Gandy

cc: Mr. Nease

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		77-02033							
1. DECEASED NAME (TYPE OR PRINT)		FIRST BARBARA		MIDDLE DOWNEY		LAST BAYLY		7a. DATE OF DEATH MONTH DAY YEAR	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 11 44		6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.		7b. HOUR 4:00 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mass.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4623 MAPLE AVE				12a. USUAL OCCUPATION (TYPE OR WORK) (MOST OF WORKING LIFE) Exec. Assistant		12b. KIND OF BUSINESS OR INDUSTRY For a Congress-man	
13a. STATE Md		13b. COUNTY MONTG		13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4623 MAPLE Ave	
14. FATHER'S NAME FIRST WILLIAM MIDDLE S. LAST DOWNEY		15. MOTHER'S MAIDEN NAME FIRST Marion MIDDLE LAST Herbert		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					
16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS John H. Bayly, Husband. Same as item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1727 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE PULMONARY FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC MALIGNANT MELANOMA									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hr 7 days 2 YRS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF INJURY, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from November 1, 1975, to January 6, 1977, that (I) (we) lost saw the deceased alive on Jan 6, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Timothy C. Bayly M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/6/77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TIMOTHY C BAYLY M.D.		22e. ADDRESS 2524 Eye St. N.W. WASH. DC. 20037							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/8/1977		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Md.			
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS, INC.		ADDRESS 5130 WISCONSIN AVENUE, N. W.		25a. DATE REC'D. BY REGISTRAR JAN 18 1977		25b. REGISTRAR'S SIGNATURE [Signature]			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02034

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>LAURA Powell Becker</b>			2a DATE OF DEATH MONTH DAY YEAR <b>1-30-77</b>			2b HOUR <b>10:10 P M</b>			
3 SEX <b>F</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-21-17</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3446 Chiswick Ct.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>George O. Powell</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruth Harber</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			
16b. SOCIAL SECURITY NO. <b>255-32-3091</b>			17 INFORMANT <b>Mrs. George B. Porter- sister-in-law</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b> <b>426X</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cor-Pulmonale</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</b> <b>2 wks.</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/1</b> , 19 <b>50</b> , to <b>1/30</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1/30/77</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John E. Everett, MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/30/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN E. EVERETT</b>						22e. ADDRESS <b>9400 CONN. AVE. KENS., MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 3, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Purtonsville Montgomery Md.</b>		
24. FUNERAL HOME <b>Verdine E. Pumphrey, Inc.</b> <b>8434 Ga. Ave. S.S. Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Pietro McCurdy</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02035 REG. NO.				
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Russell NMI Beers						JAN. 3 1977						M		
3 SEX Male			4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR 4 0 10			6 AGE (IN YEARS LAST BIRTHDAY) YRS 66			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.			7b. CITIZEN OF WHAT COUNTRY? U.S.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10 CITY OR TOWN OF DEATH Silver Springs			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CRANE OPERATOR			12b. KIND OF BUSINESS OR INDUSTRY STEEL MILL		
13a. STATE MD.			13b. COUNTY Mont.		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3114 University Blvd.					
14. FATHER'S NAME FIRST MIDDLE LAST TICE BEERS						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET B. LUCAS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS SHIRLEY BAILEY GORMAN AVE LAUREL MD								
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538 CARCINOMATOSIS WITH OBSTRUCTION DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF COLON DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MON 1 YEAR				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):														
19a. DATE OF OPERATION 14 DEC 1976			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED INTESTINAL OBSTRUCTION				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (1) <del>this hospital</del> attended the deceased from 3 DEC 1976, to 3 JAN 1977, that (1) <del>was</del> lost saw the deceased alive on 2 JAN 1977, and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>was</del> <del>did not</del> view the body after death.														
22b. SIGNATURE Harold S. Liden M.D.						DEGREE M.D.			22c. DATE SIGNED 3 JAN 1977					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Buried			23b. DATE JAN 5, 1977		23c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore - Harwood - MD						
24. FUNERAL DIRECTOR NAME David J. H.						25. DATE REC'D. BY REGISTRAR JAN 10 1977			25b. REGISTRAR'S SIGNATURE P. J. McCreedy					

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02036

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JONAS GRASON Bell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-16-77</b>			2b. HOUR <b>5:30</b> M			
3. SEX <b>male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 19, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KENSINGTON GARDENS</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>INSTRUMENT MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NOL</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10607 SOUTH DUNNMOOR DRIVE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JONAS BELL</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARTHA ANGLE</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-07-4171A</b>		17. INFORMANT ADDRESS <b>LORETTA BELL SAME AS 13 WIFE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>581X IMMEDIATE CAUSE (a) UREMIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>NEPHROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>SENSITIVITY</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>1/10/77</b> to <b>1/16/77</b> , that (I) (we) last saw the deceased alive on <b>1/15/77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Thos G. Ward</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-16-77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. Ward</b>						22e. ADDRESS <b>6116 ROBINWOOD, BETHESDA, MD 20834</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/19/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST PAUL'S CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CLEAR SPRING WASH MD.</b>			
24. FUNERAL DIRECTOR'S NAME <b>FRANCIS J. COLLINS</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McBrady</b>	
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901									

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

11

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		77-02037 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Daniel D. Berberian</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 19, 1977</b>		2b. HOUR <b>5<sup>15</sup> AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Armenian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 23, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Mr Unknown Berberian</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mrs Unknown Ambarjian</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>088-01-5074</b>		17. INFORMANT <b>Ruth Hanessian</b>		ADDRESS <b>17700 Stonedridge Dr</b>	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>198X</b> IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Unilateral ptosis and ptosis of blood</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>arteriosclerosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>arteriosclerosis</b>							
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-15</b> , 19 <b>77</b> , to <b>1-19</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1-15</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John D. Maylath</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-19-77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN D. MAYLATH</b>				22e. ADDRESS <b>30 W. EDMUNDSON DR ROCKVILLE, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>1-21-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LEE CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASINGTON D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>				24b. ADDRESS <b>246 N. W. 36th ST. Rockville MD</b>		25a. JAN 24 1977 BY REGISTRAR <b>John D. Maylath</b>	

1901-11

(M)

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02038

REG. NO.

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>HOWARD</b>		FIRST <b>HOWARD</b> MIDDLE LAST <b>BERGER</b>		2a DATE OF DEATH MONTH <b>1</b> DAY <b>20</b> YEAR <b>77</b>			2b HOUR <b>12 Noon</b>		
3 SEX <b>Male</b>		4 RACE <b>CAUCASIAN</b>		5 DATE OF BIRTH MONTH <b>6</b> DAY <b>22</b> YEAR <b>12</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD			
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Liquor</b>		
13a STATE <b>Maryland</b>		13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Silver Spring</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>10718 Tenbrook Drive,</b>	
14 FATHER'S NAME FIRST <b>Isadore</b> MIDDLE LAST <b>Berger</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Esther</b> MIDDLE LAST <b>Berger</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. <b>182-09-2193</b>		17 INFORMANT ADDRESS <b>Mrs. Catherine Berger (Same as # 13)</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock.</b> <b>14109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction 1 hr.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary heart disease.</b> <b>8+ yrs</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <b>1968</b> , 19____, to <b>1/20/77</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/20/77</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Bernard J. Walsh, M.D.</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/20/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Bernard J. Walsh</b>				22e ADDRESS <b>1500 Eye St. N.E. - D.C.</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/23/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEM. GARDEN</b>		23d. LOCATION CITY OR TOWN <b>FALLS CHURCH</b> COUNTY <b>VIRGINIA</b> STATE			
24 FUNERAL DIRECTOR NAME <b>D.M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>				25a DATE REC'D. BY REGISTRAR <b>JAN 25 1977</b>		25b REGISTRAR'S SIGNATURE <b>John J. McCreedy</b>			
232 CARROLL STREET, N.W., WASHINGTON, D.C.									

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

85030





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02039

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Neil Patrick Berney</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-6-77</b>			2b. HOUR <b>4:15 A.M.</b>				
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-19-XX 1911</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kan.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>XXXXXX USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Dept of Agriculture</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Zip-20901</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10621 South Dunmoor Drive.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Peter Berney</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Sullivan</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>579-10-4659</b>		17 INFORMANT ADDRESS <b>Agnes S. Berney Same as 13 Wife</b>					

## MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4124</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anterograde Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Anterograde Cardiac Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
**Renal Insufficiency**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>December 12, 1976</b> to <b>Jan 6, 1977</b> , that (I) (we) lost saw the deceased alive on <b>Jan 5, 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Bernard A Fitzgerald</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-6-77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARD A FITZGERALD</b>				22e. ADDRESS <b>217 UNIVERSITY BLVD EAST SILVER SPRING MD</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/10/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Leo's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Horton Kansas</b>	
24 FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>				25a. DATE RECEIVED BY REGISTRAR <b>JAN 10 1977</b>		25b. REGISTRAR'S SIGNATURE <b>B. J. Brady</b>	
25c. ADDRESS <b>500 Univ. Blvd., W., Silver Spring, Md. 20901</b>							



1701 XV 171

1701 XV 171

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02040

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ANNA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-30-77</b>			2b. HOUR <b>1:45</b> P M		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>September 13, 1891</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Latvia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			8. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>85</b> YRS		
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
13a. STATE <b>New York</b>			13b. COUNTY <b>Queens</b>			13c. CITY OR TOWN <b>Flushing</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Moses Meyerowitz</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Isaacson</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>081-01-5379</b>			17. INFORMANT ADDRESS <b>810 Gregorio Drive, Silver Spring, Md.</b>		
18. CAUSE OF DEATH Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 3959 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Calcific aortic Stenosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>?</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few months</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>11/22</b> , 19 <b>76</b> to <b>1/30</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1/30</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Antonio G. Uy</b>			DEGREE <b>MD</b>			22c. DATE SIGNED <b>1/30/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTONIO G. UY</b>			22e. ADDRESS <b>831 Univ. Blvd E #25 Silver Spring Md 20903</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>2/2/1977</b>			23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT ZION CEMETERY</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>MASPETH, QUEENS, NEW YORK</b>			24. FUNERAL DIRECTOR NAME <b>DONALD M. STEIN</b>			25. DATE REC'D BY REGISTRAR <b>B 4 1977</b>		
24. FUNERAL DIRECTOR ADDRESS <b>232 CARROLL STREET, N.W., WASHINGTON, D. C.</b>			25. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>					

MEDICAL CERTIFICATION

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

04730-11

Released by Medical Examiner  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 77-02041				
1. DECEASED NAME (TYPE OR PRINT) FIRST GLENN MIDDLE E. LAST BINNS GLENN EDWARD BINNS					2a. DATE OF DEATH MONTH DAY YEAR JAN 26 1977			2b. HOUR 6:49 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 20 1901		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Painter (Foreman)		12b. KIND OF BUSINESS OR INDUSTRY Mt. Alto Hospital	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. COUNTY Md. 20795 Montgomery		13c. CITY OR TOWN Kensington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4302 Warner St.			
14. FATHER'S NAME FIRST MIDDLE LAST John A. Binns				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (Unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW1		17. INFORMANT Matthew F. Binns, Son.		ADDRESS Annandale, Va. 4114 Mangalere Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC CORART DIS (c) DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HR YRS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CONG. HEART FAILURE									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) (hospital) attended the deceased from 19 70, to 1/26 19 77, that (we) (we) last saw the deceased alive on 12/13 19 76, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Daniel Rosenblum				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/26/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM				22e. ADDRESS 10400 CONNECTICUT AV. KENSINGTON, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/31/1977		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.			
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS INC.				ADDRESS 2000 WISL AVE. N. W. WASH. D. C. 20016		25a. DATE REC'D BY REGISTRAR JAN 31 1977		25b. SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR REG. NO. <b>77-02042</b>											
1. DECEASED NAME (TYPE OR PRINT) <b>Phyllis M. Blair</b>						2a. DATE OF DEATH MONTH <b>1</b> DAY <b>27</b> YEAR <b>77</b>			2b. HOUR <b>5<sup>45</sup> a.m.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Mar.</b> DAY <b>9</b> YEAR <b>1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS. MONTH <b>48</b>			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3913 Lawrence Ave.</b>			
14. FATHER'S NAME FIRST <b>Edward A.</b> MIDDLE <b>Camp</b> LAST						15. MOTHER'S MAIDEN NAME FIRST <b>Lillian</b> MIDDLE LAST <b>Johnson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>578-34-1700</b>		17. INFORMANT ADDRESS <b>Lewis R. Blair SAME as # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe Congestive Heart Failure</b> <b>4270</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe Chronic Passive Congestion - Liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiomegaly - Myocarditis</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST <b>2-3 days</b> <b>2 days</b> <b>3 years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic Asthma. Bronchopneumonia</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>MAR</b> , 19 <b>73</b> , to <b>27 JAN</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>27 JAN</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>E. P. Libe</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>28 Jan 1977</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Eugene P. Libe</b>						22e. ADDRESS <b>10400 Conn Ave Kensington Md 20785</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/31/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wis. Ave. N.W. Wash., D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1977</b>			25b. REGISTRAR'S SIGNATURE <b>Dorothy McCready</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 77-02043									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P M	
Evelyn		M.				Blick		January 26, 1977		9:00 P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
Female		Caucasian		Oct 20 1888		88 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.				Montgomery, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Kensington		Kensington Gardens Nurs Home									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Homemaker		Home									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Montgomery		Bethesda				9508 Page Avenue			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Edward Yeatman						Charlotte Foley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				256 52 0888		Jane Meatyard daughter same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4369 Cardio Arrest										30 min	
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.										30 days	
DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Cerebro Vascular Acc'd's											
DUE TO, OR AS A CONSEQUENCE OF (c) Cerebro Vascular Acc'd't										7 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
Chronic Brain Syndrome											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/30 1976 May 1970, to 1/26 1977, that (I) (we) last saw the deceased alive on 12/30 1976, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE DEGREE Frank J. Jagers, MD										22c. DATE SIGNED 1/27/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frank Jagers, MD										22e. ADDRESS 6000 Executive Blvd, Rockville MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/29/77		23c. NAME OF CEMETERY OR CREMATORY Westview Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE JAN 31 1977			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND		25. DATE REC'D. BY REGISTRAR 25f. REGISTRAR'S SIGNATURE									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <u>LARRY</u> <u>Leon</u> <u>BLUNT</u>						2a. DATE OF DEATH Month <u>10</u> Day <u>13</u> Year <u>77</u>			2b. HOUR <u>5:00</u> M		
3. SEX <u>M</u>		4. RACE <u>B</u>		5. DATE OF BIRTH <u>7-27-69</u>		6. AGE (In years last birthday) <u>8</u> YRS.		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS. HOURS <u>0</u> MIN <u>0</u>	
7a. BIRTHPLACE (State or foreign country) <u>BALTO.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>US</u>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Montgomery</u> Md.					
10. CITY OR TOWN OF DEATH <u>SILVER SPRING</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Great Oaks Center</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Forestry</u>			12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MD</u>		13b. COUNTY <u>P.G.</u>		13c. CITY OR TOWN <u>Forestville</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>6573 Hillmar Dr.</u>			
14. FATHER'S NAME First <u>Leon</u> Middle <u>Douglas</u> Last <u>BLUNT</u>				15. MOTHER'S MAIDEN NAME First <u>Doris</u> Middle <u>BLUNT</u> Last <u>BLUNT</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Forestville, Md.</u> <u>DORIS DOUGLAS 6573 Hillmar Dr.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-pulmonary arrest</u> <u>7439</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>micro-ephy, spastic quadriplegia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>mental retardation</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>mental retardation</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 28</u> , 19 <u>72</u> , to <u>Jan 13</u> , 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>Jan 13</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>G.E. Greene MD</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>JAN 13 1977</u>					
22d. PHYSICIAN'S NAME (Type) <u>Geoffrey E. Greene MD</u>		22e. ADDRESS <u>Great Oaks Center, Silver Spring, MD</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>1-17-77</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>Clinton Maryland</u>					
24. FUNERAL DIRECTOR <u>WILLIAM REESE &amp; SONS MORTUARY, P.A.</u>		ADDRESS <u>Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 18 1977</u>		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>					

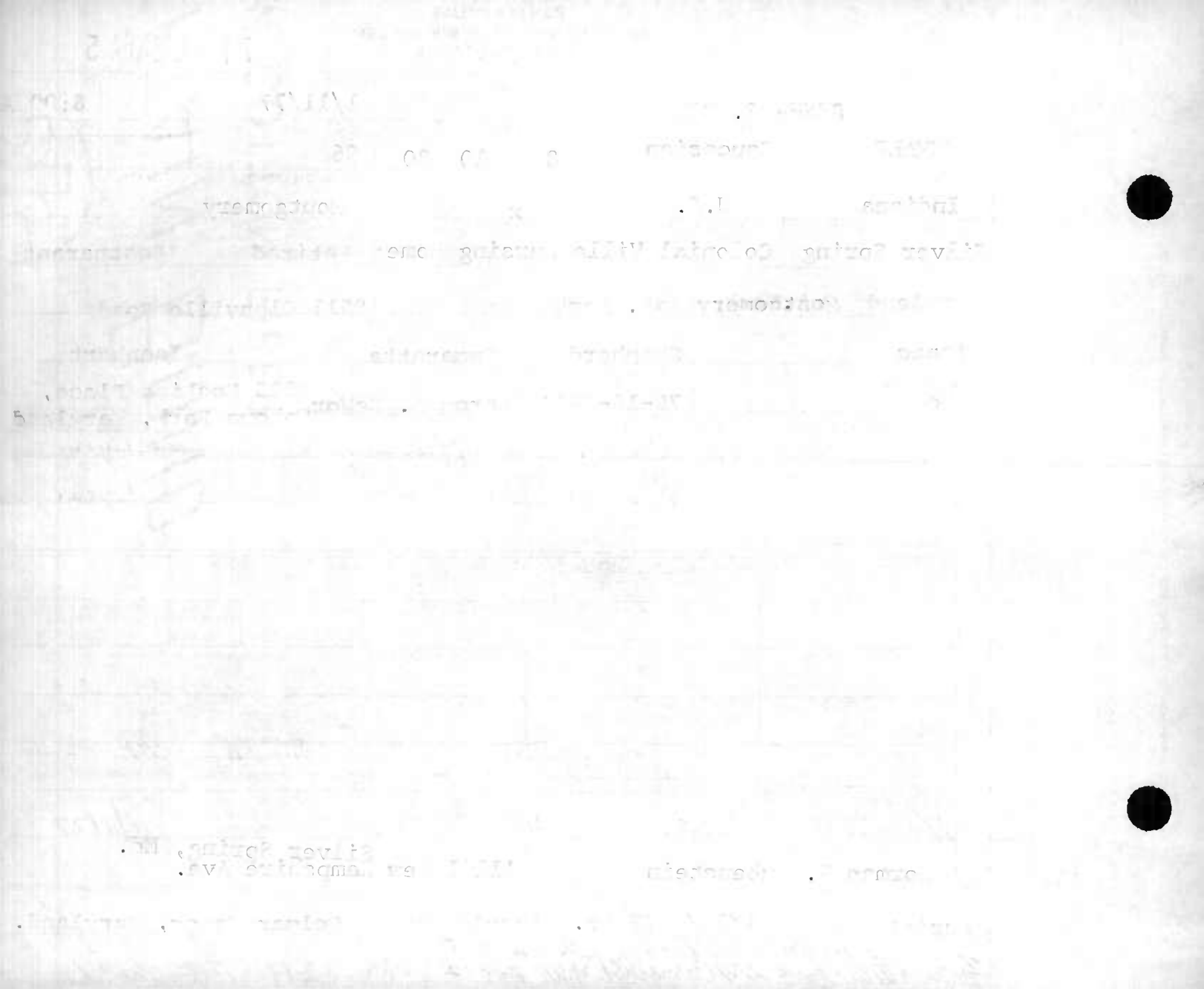


DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02045

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>DESHA S. BOX</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1/11/77</b>			2b. HOUR <b>8:00 AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 10 80</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Colonial Villa Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restuarant</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Tak. Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Isaac Shepherd</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emmaretta Isenhardt</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-16-2444</b>		17. INFORMANT <b>George A. DeVor</b> ADDRESS <b>8505 Hoskins Place, Takoma Park, Maryland</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4337</b> IMMEDIATE CAUSE (a) <b>Cerebral insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) 1 year 1 year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec.</b> , 19 <b>75</b> , to <b>Jan. 11</b> , 19 <b>77</b> , that (we) lost saw the deceased alive on <b>Jan. 11</b> , 19 <b>77</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) did ( <del>did not</del> ) view the body after death.									
22b. SIGNATURE <b>Norman H. Rubenstein</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/11/77</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Norman H. Rubenstein</b>		22e. ADDRESS <b>11161 New Hampshire Ave. Silver Spring, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/14/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Colmar Manor, Maryland.</b>			
24. FUNERAL DIRECTOR NAME <b>Arthur Walters</b>		ADDRESS <b>254 Carroll St. N.W. Wash. D.C. 20012</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCall</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02046

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ruth Brewer</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 29 77</b>			2b. HOUR <b>12:28PM</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 22, 1895</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>			
10 CITY OR TOWN OF DEATH <b>Silver Spring, MD</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital of Silver Spring</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ernest B. Emmert</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Prude Boteler</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no --</b>			
16b. SOCIAL SECURITY NO. <b>217-10-0050</b>		17 INFORMANT ADDRESS <b>D Philip Brewer, 12545 Two Farm Dr</b>				18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular rupture</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4/109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>75 min</b>		5 hours		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>					
19a. DATE OF OPERATION <b>NA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/29</b> , 19 <b>77</b> , to <b>1/27</b> , 19 <b>77</b> , that (I) <del>lost</del> saw the deceased alive on <b>1/29</b> , 19 <b>77</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) (do not) view the body after death.									
22b. SIGNATURE <b>John H. Tuohy, MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>1/29/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN H. TUOHY, M.D.</b>				22e. ADDRESS <b>1500 FOREST GLEN RD SILVER SPRING, MD 20910</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/1/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hagerstown, Wash. Md.</b>			
24 FUNERAL DIRECTOR NAME <b>A. K. Coffman Funeral Home, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick McCready</b>			



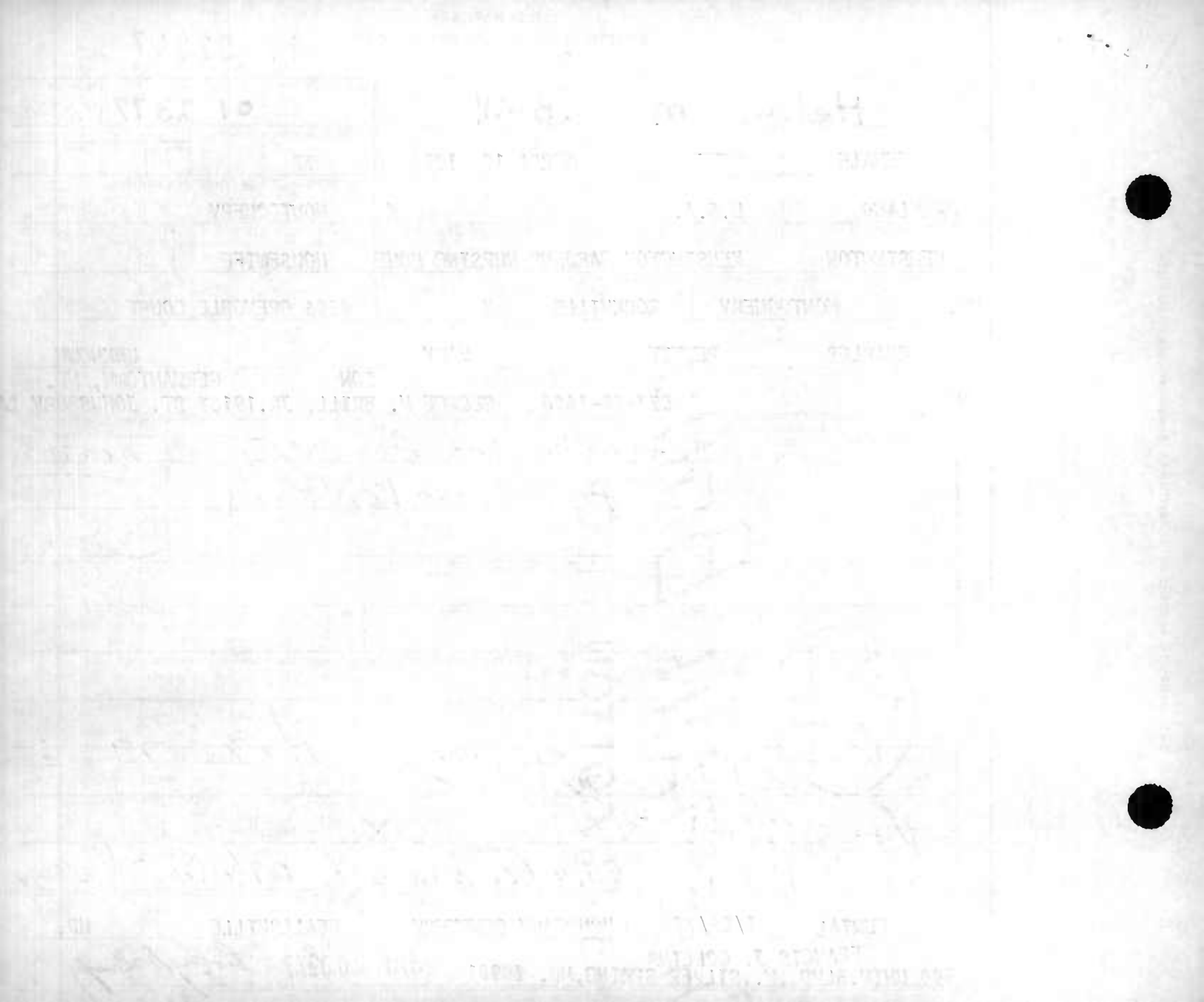


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02047 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Helen m Brill</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>01 23 77</b>			2b. HOUR <b>7:25 AM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 17, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KENSINGTON GARDENS NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>ROCKVILLE</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>4506 GRENOBLE COURT</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES PETTIT</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>577-09-1600</b>		17. INFORMANT ADDRESS <b>SON GERMANTOWN, MD. GEORGE M. BRILL, JR. 19137 ST. JOHNSBURY LA</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4124 Cardiovascular Accident</b> IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>10 29 76</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>6116 Robinwood Pl Bethesda, Md 20034</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/29/76</b> to <b>1/23</b> 19 <b>77</b> , that (I) <del>lost</del> saw the deceased alive on <b>12/14</b> 19 <b>76</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <del>yes</del> (did) (did not) view the body after death.											
22b. SIGNATURE <b>Thos G. Ward</b> DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <b>20034</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. Ward</b>				22e. ADDRESS <b>6116 Robinwood Pl Bethesda, Md 20034</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>1/26/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MONOCACY CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BEALLSVILLE MD.</b>			
24. FUNERAL DIRECTOR'S NAME <b>FRANCIS J. COLLINS</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1977</b>		25b. REGISTRAR'S SIGNATURE <b>John McCreary</b>			
24. FUNERAL DIRECTOR'S ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>											





STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										77-02048 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
John		Asa		Brockwell				X MONTH DAY YEAR 1 18 19 77		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD	
Male	White	Nov. 29, 1947		29		MONTHS DAYS HOURS MIN				1 18 19 77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		X NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		12. HOUR	
D.C.		USA		WIDOWED		DIVORCED		Montgomery County		12:35 P M	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Suburban Hospital		Property Manager		Promenade					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland		Montgomery		Derwood		YES <input type="checkbox"/> NO X		17730 Milcrest Rd.			
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST	
James		W.		Brockwell		Florence				Damron	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		577-64-9316		Maria O. Brockwell		Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Smoke and soot inhalation</b> 89DX DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
										YES XX NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED							
X		11:00 A. 1/18 19 77		Caught in elevator in burning building							
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION							
X		Apartment bld.		5225 Pooks Hill Rd., Bethesda, Montgomery, Md.							
22. I certify that I took charge of the remains described above, held an Autopsy XX, Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident X Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED			
Bert F. Morton		Deputy Chief						1/19/77			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Bert F. Morton, M.D.		111 Penn St., Baltimore, Md.		21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		STATE	
Burial		1/21/77		Gate of Heaven Cem.		Silver Spring, Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Joseph Gawler's Sons, Inc.		JAN 25 1977		Dietrich McBrady							
NAME		ADDRESS									
5130 Wisc. Ave. N.W.		Wash., D.C.									

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02049

REG NO

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Richard Irving Brown</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 31 77</b>			2b. HOUR <b>10<sup>20</sup> PM</b>			
3 SEX <b>M</b>		4 RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 17 81</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>95</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>P.G. Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co. MD.</b>			
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Chevy Chase Convalescent Ctr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Machinist-Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Navy Dept</b>	
13a. STATE <b>Va.</b>			13b. COUNTY <b>Fairfax</b>		13c. CITY OR TOWN <b>Springfield</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Richard F. Brown</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Judith Gravatt</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>226 62 6712</b>			17 INFORMANT ADDRESS <b>Bethesda, Md. Constance Burger 9200 Seven Locks Rd.</b>						

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>
(b) <b>4124</b>		
(c) <b>4124</b>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): **Acute Gastro-enteritis**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10-29 1976</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-29 1976</b> to <b>31 Jan 77</b> , that (I) (we) lost <b>31 January 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Samuel Dove - M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1 Feb 1977</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SAMUEL DOVE</b>		22e. ADDRESS <b>818-18th St, N.W. # 240 - Washington DC</b>		22f. <b>20006</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/3/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Sam E. Williams</b>		24b. ADDRESS <b>520 S. Washington St. W.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 8 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

77-02050

1. DECEASED NAME (TYPE OR PRINT) CATHERINE VERONICA BUCKLEY			2a. DATE OF DEATH MONTH DAY YEAR 11/14/77			2b. HOUR 6:40 P.M.			
3. SEX FEMALE		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11 5 1890		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RANDOLPH HILLS				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD BURNS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 230-16-0971D		17. INFORMANT ADDRESS Mrs. Catherine Weigel Same as #13					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: H123 IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) CORONARY ARTERY Disease		10 YRS	
DUE TO, OR AS A CONSEQUENCE OF (c) OLD AGE			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from June 13, 1970, to Jan 13, 1977, that (I) (we) lost saw the deceased alive on Jan 13, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L. J. Toron M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/15/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. L. J. TORON		22e. ADDRESS 8218 WISCONSIN AVE Bethesda MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-18-77		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR JAN 19 1977		25b. REGISTRAR'S SIGNATURE History McCreedy	



CH 1

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LIBRARY

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

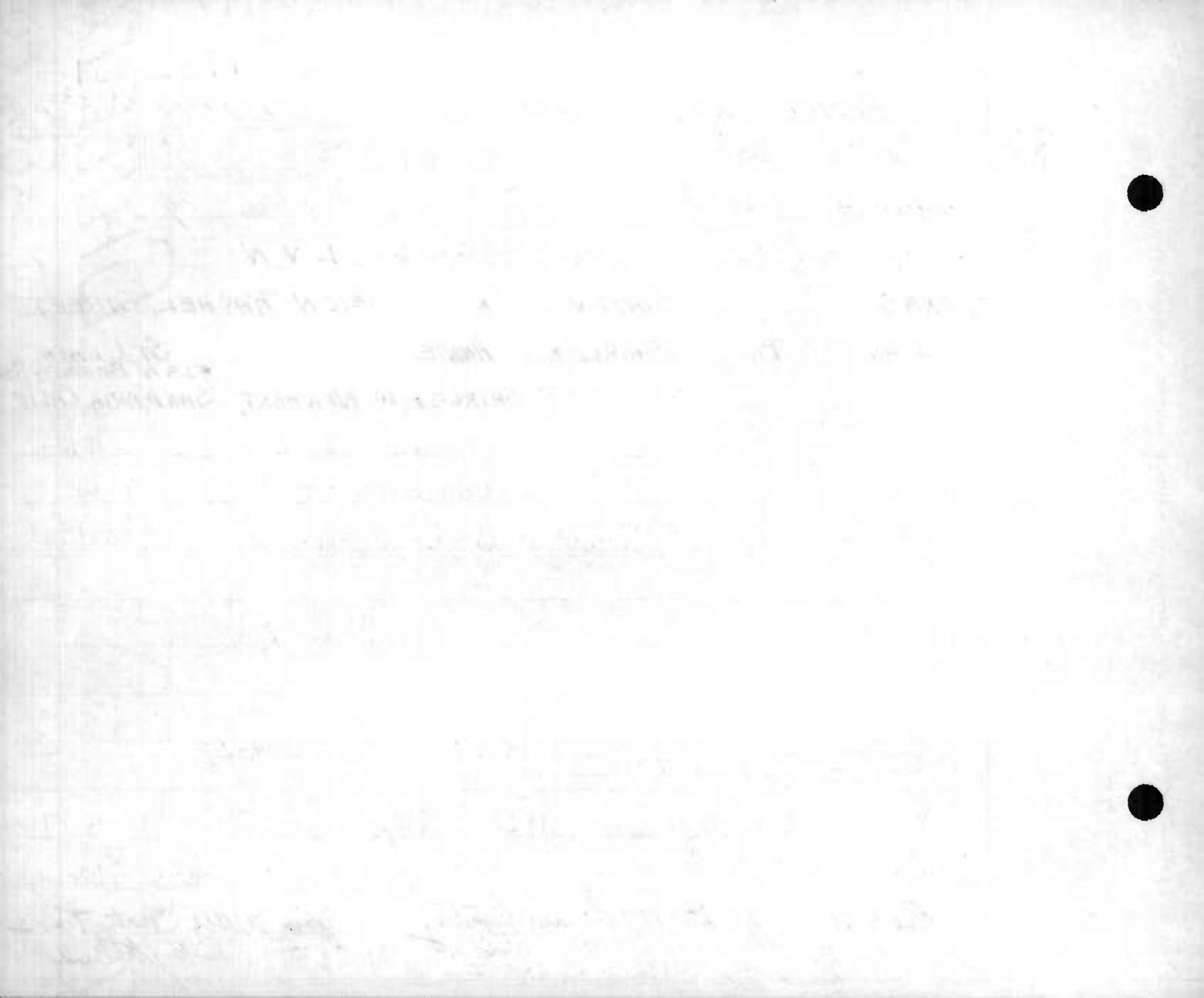


1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02051

1. DECEASED NAME (TYPE OR PRINT) <b>BERTHA LEE BURK</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-19-1977</b>		2b. HOUR <b>3:35 P.M.</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 16, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ALABAMA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>L.V.N.</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>TEXAS</b>		13b. COUNTY <b>SINTON</b>		13c. CITY OR TOWN <b>SINTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN B. SHIRLEY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNIE ST. CLAIR</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>462-24-1456</b>	
17. INFORMANT ADDRESS <b>SHIRLEY M. NEWHART, 523 N. BRADLEY RD, SAN MARIA CALIF.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: <b>4319 IMMEDIATE CAUSE (a) Brain Death</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Subarachnoid hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Gradual</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>29 h + 4 da</b>		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:	
19a. DATE OF OPERATION <b>1-15-77</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. I certify that (I) (the hospital) attended the deceased from <b>1-15-77</b> 19 to <b>1-19-77</b> 19, that (I) (we) last saw the deceased alive on <b>1-18-77</b> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22. DATE SIGNED <b>1-19-77</b>	
22a. SIGNATURE <b>Jona than M. Williams</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. ADDRESS <b>808 Pershing Dr. S.W. Sp.</b>	
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jona than M. Williams</b>		22d. ADDRESS <b>808 Pershing Dr. S.W. Sp.</b>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 24, 1977</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sancta Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>San Antonio County Texas</b>		24. FUNERAL DIRECTOR NAME <b>Arthur Walters</b>		25. DATE RECEIVED BY REGISTRAR <b>JAN 24 1977</b>	
26. SIGNATURE OF FUNERAL DIRECTOR <b>Arthur Walters</b>		27. SIGNATURE OF REGISTRAR <b>Helen McCreedy</b>		28. SIGNATURE OF REGISTRAR <b>Helen McCreedy</b>		29. SIGNATURE OF REGISTRAR <b>Helen McCreedy</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02052		
1. FOR STATE REGISTRAR					2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR						2b. HOUR	
Annie Olga Annie Bush					1 1 77						10:45 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Female		W		1 31 1896		80 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Baltimore M.D.		USA				Montgomery MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Gaithersburg		Herman Wilson Medical C.		Housewife		Home						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
M.D.		CARROLL		Finksburg				Box 20				
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Henry CATTENDEN Isaacs					Annie EYRE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
NO					—		6514 Windsor Mill Rd 219-20-2524 Mrs Olga Durgin Baltimore Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Pneumonia, lobar												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
PROLapsed Rectum												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death		12/30/76		11/1/77		1977		that (I) (we) lost and that in (my) (our) opinion death occurred on the date and hour and from the causes stated				
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/1/77						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										
6116 ROBINWOOD RD		Bethesda, Md		THOS G. WARD, M.D.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial		1-4-77		Providence Cemetery		Finksburg Carroll Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
Harry W. Haight		Sykesville, Md.		JAN 6 1977		Anthony McCreedy						

17-05025

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CHICAGO, ILL. 60607

Handwritten notes and diagrams on lined paper. The text is mostly illegible due to fading and bleed-through. Faintly visible words include "The University of Chicago", "Library", "500 East Hall", "Chicago, Ill. 60607", "The University of Chicago", "Library", "500 East Hall", "Chicago, Ill. 60607". There are also some numbers and symbols, such as "17-05025" at the top left and "17-05025" at the bottom left. A large, faint circular stamp or logo is visible in the center of the page.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02053

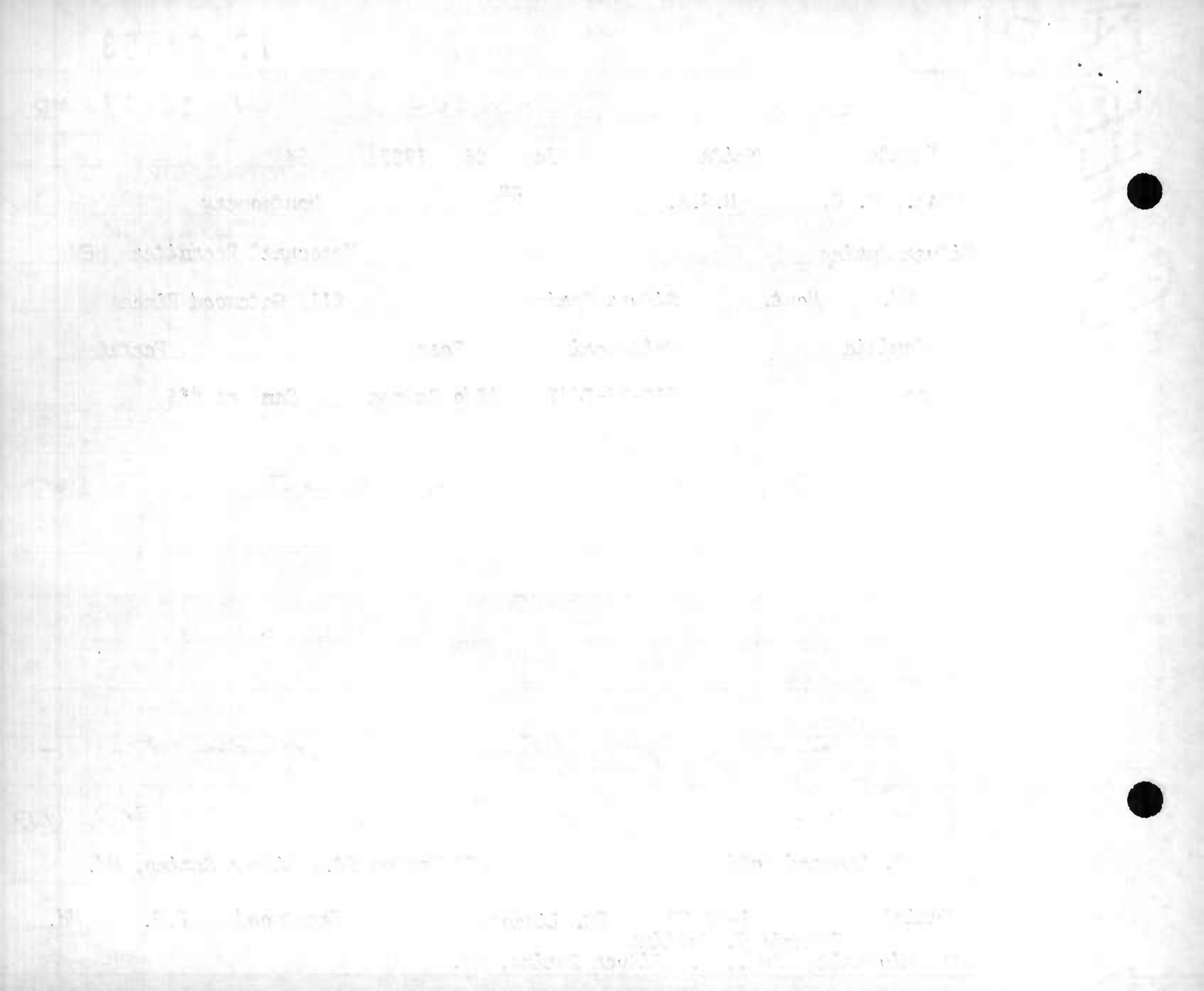
1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>ADELE C. CAMANA</b>			2a DATE OF DEATH MONTH DAY YEAR <b>1-26-77</b>			2b HOUR <b>3:30 P.M.</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Jan 26 1923</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D. C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2115 GATEWOOD PL.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Personnel Recruiter</b>		12b KIND OF BUSINESS OR INDUSTRY <b>HEW</b>	
13a STATE <b>Md.</b>		13b COUNTY <b>Mont.</b>		13c CITY OR TOWN <b>Silver Spring</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>2115 Gatewood Place</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Dominic Callegari</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosa Partel</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-36-7447</b>		17 INFORMANT <b>Aldo Camana</b>		ADDRESS <b>Same as #93</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Transition</b> <b>174X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (b) <b>Adenocarcinoma of Breast</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b> <b>3 1/2 yrs.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>May</b> , 19 <b>75</b> , to <b>Jan 26</b> , 19 <b>77</b> , that (I) <del>lost</del> saw the deceased alive on <b>Jan 20</b> , 19 <b>77</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>will</del> (did) (did not) view the body after death.									
22b. SIGNATURE <b>G. Lennard Gold, M.D.</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>Jan 26, 1977</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Lennard Gold</b>						22e. ADDRESS <b>8630 Fenton St., Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-29-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P.G. Md.</b>		
24 FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Bartholomew</b>	
500 University Blvd., W., Silver Spring, Md.									

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

77-02054

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Margaret B. Camp</b>			2a DATE OF DEATH MONTH DAY YEAR <b>January 24, 1977</b>			2b HOUR <b>8:25 P</b>				
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 23, 1889</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10 CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens Nurs. Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b>			13b COUNTY <b>Montg.</b>		13c CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5804 Linder Lane</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John A. Bacon</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leila Sallee</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b SOCIAL SECURITY NO. <b>579-22-0450</b>		17. INFORMANT ADDRESS <b>Dorothy West Same as 13</b>				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>5 yrs.</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Severe Rheumatoid arthritis.</b>										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/1/1960</b> to <b>1/24/1977</b> that (I) (we) lost saw the deceased alive on <b>1/22/1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>S.W. Nealon Jr</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/24/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S.W. Nealon, Jr.</b>						22e. ADDRESS <b>915 - 19th St. NW Wash., D.C.</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>Jan. 27, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1977</b>		25b. REGISTRAR'S SIGNATURE <b>my McBrody</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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• 1990 •



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		77-02055 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MARY MIDDLE Letitia LAST CAMPBELL		2a. DATE OF DEATH MONTH DAY YEAR 1 31 77 2b. HOUR 6:15A.M.	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 9 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6 AGE (IN YEARS LAST BIRTHDAY) 98 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sharon Nursing Home		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Takoma Park	
14 FATHER'S NAME FIRST John MIDDLE Scott LAST Brown		15. MOTHER'S MAIDEN NAME FIRST Celestia MIDDLE Letitia LAST Daniels		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-34-1225 213-38-1579		17 INFORMANT ADDRESS F2 Nancy Lindquist, 8204 Reservoir Rd	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 404X IMMEDIATE CAUSE (a) Cardiorespiratory Failure		DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c) Anterograde C.V. Renal Disease		8 days	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I Hemiparesis				years	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/2 19 76 to 1/31 19 77, that (I) (we) lost saw the deceased alive on 1/31 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) examine the body after death.		22b. SIGNATURE [Signature]		22c. DATE SIGNED 1/31/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. H. LIGON		22e. ADDRESS 1811 P. Philip Dr., Olney MD 20832		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial		23b. DATE 2/2/77		23c. NAME OF CEMETERY OR CREMATORY George Wash. Cem.	
23d. LOCATION CITY OR TOWN County State Adelphi, Maryland		23e. DATE REC'D. BY REGISTRAR FEB 7 1977		23f. REGISTRAR'S SIGNATURE [Signature]	
24. FUNERAL DIRECTOR NAME Hines/Ronald		ADDRESS 11800 New Hampshire Ave		25a. DATE REC'D. BY REGISTRAR FEB 7 1977	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 77-02056

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE ESTIMATED		2d. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		MONTH DAY YEAR	
William E. Carter		1 15 19 77		10:20 A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
Male	Black	Aug. 14, 1914	62 YRS.	MONTHS DAYS HOURS MIN.	MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.	U.S.A.	WIDOWED	DIVORCED	Montgomery County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Laytonsville	Wooded field 3/4 mile from Brink Rd.	Unemployed			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland		Montg.	Laytonsville	YES <input type="checkbox"/> NO <input type="checkbox"/>	Box 956
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
William Carter		Maude Jackson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
(YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		John Carter (Brother) same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cold exposure complicating chronic alcoholism					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION		
			STREET CITY OR TOWN COUNTY STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Bert F. Morton		Deputy Chief		1/23/77	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Bert F. Morton, M.D.		111 Penn St., Baltimore, Md. 21201			
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial	1-26-77	Brooke Grove Cemetery		Gaithersburg, Mond. Maryland	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
George R. Snowden		JAN 26 1977		[Signature]	
246 N. Washington St. Rockville, Md. 20850					

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

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UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 25M  
(VR A 15 (4) ) 9/74

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

77-02057

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROBERT F. CARTWRIGHT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-1-77</b>			2b. HOUR <b>6:29 PM</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 3 07</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FEARWOOD HOUSE</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Consul General</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>State Dept.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>11138 STEPHALEE LANE</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>CYRUS MITCHELL CARTWRIGHT</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CATHERINE McMANUS</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>	
16a. SOCIAL SECURITY NO. <b>577-60-4996</b>		17. INFORMANT <b>C. GENEVIEVE CARTWRIGHT</b>		18. SAME AS 13 SISTER			

18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

188X

IMMEDIATE CAUSE (a)

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **C metastases**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Abdominal Cavity**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

3 mos.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION <b>9/76 + 11/76</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma Bladder</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/76</b> 19 to <b>1/1</b> 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1/1</b> 19 <b>77</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <b>Blaine Fitzgerald</b>		22c. DATE SIGNED <b>1/1/77</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>D. BLAINE FITZGERALD</b>		22e. ADDRESS <b>8218 Wise Ave. Bethesda Md.</b>		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/5/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>mt. olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D. C.</b>	
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24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	
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12-1-51

RECEIVED  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

General (General)

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WASHINGTON, D.C.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

REG. NO. 77-020581. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>John Thomas Chain</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>01 18 1977</b>		2b. HOUR <b>3:37A M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 22 1908</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MASSACHUSETTS</b>		8. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>				
11. CITY OR TOWN OF DEATH <b>Olney</b>		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RET. EXECUTIVE</b>		
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE <b>NEW JERSEY</b>		14b. COUNTY <b>UNKNOWN</b>		14c. CITY OR TOWN <b>BRICKTOWN</b>		
15. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16. STREET ADDRESS <b>2 HANLEY COURT</b>				
17. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN A. CHAIN</b>		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ADELAIDE THOMAS</b>				
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>UNKNOWN</b>		19b. SOCIAL SECURITY NO. <b>146-09-6763</b>		19c. INFORMANT ADDRESS <b>COL. J.T. CHAIN, JR. - LANGLEY AIR FORCE BASE, VA.</b>		
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>5769</b> IMMEDIATE CAUSE (a) <b>Inanition - Dehydration</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Biliary tract disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Type pending</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>2 yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Nephrosclerosis, COPD, Coronary Artery Disease.</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>OLNEY, Md</b>		
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 25</b> , 19 <b>76</b> , to <b>Jan 18</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.						
22b. SIGNATURE <b>Richard A. Yates</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/19/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard A. Yates</b>		22e. ADDRESS <b>OLNEY, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-22-1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GREENHILL CEM.</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>WILMINGTON, DELAWARE</b>						
24. FUNERAL DIRECTOR NAME <b>HYSONG FUNERAL HOME -1300-N STREET, N.W. WASH.</b>		D.C. ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1977</b>		
				25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.







DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO 77-02059

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LIZZIE G. CHEESMAN</b>		2a. DATE OF DEATH MONTH <b>JAN</b> DAY <b>24</b> YEAR <b>1977</b>		2b. HOUR <b>12 PM</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>JULY</b> DAY <b>29</b> YEAR <b>1888</b>	
6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		10 CITY OR TOWN OF DEATH <b>WHEATON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11952 ANDREW STREET</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SUPERVISOR</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STATE SCHOOL</b>		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13b. STREET ADDRESS <b>11952 ANDREW STREET</b>		14. FATHER'S NAME FIRST <b>GEORGE</b> MIDDLE <b></b> LAST <b>SOUDER</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ELIZABETH</b> MIDDLE <b></b> LAST <b>BUTTON</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-34-3284A</b>		17. INFORMANT ADDRESS <b>GEORGE L. CHEESMAN SAME AS 13 SON</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>REFRACTORY MEGALOBlastic ANEMIA</b> <b>2819</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR &amp; CEREBROVASCULAR DISEASES</b>			
19a. DATE OF OPERATION <b></b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b></b> P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) <b></b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b></b>	21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>JULY</b> 19 <b>73</b> to <b>JAN</b> 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>1-24</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Richard A. Pollen</b>		22c. DATE SIGNED <b>1-24-77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD A. POLLEN</b>		22e. ADDRESS <b>10400 CONNECTICUT AVE, KENSINGTON, MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>1/27/77</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SILLOAM CEMETERY</b>	23d. LOCATION CITY OR TOWN <b>VINELAND</b> COUNTY <b>CUMBERLAND</b> STATE <b>N.J.</b>
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1977</b>	25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 17-02060

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas <i>Elbert</i> Chester			2a. DATE OF DEATH MONTH DAY YEAR 1-16-77		2b. HOUR 11:25 PM
3 SEX Male	4 RACE Cau.	5 DATE OF BIRTH MONTH DAY YEAR March 5 1926	6 AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Takoma Park	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital Sub. Sta. Mech. Pepco		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Box 24-B		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Tracys Landing	13d. INSIDE CITY LIMITS? <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas A. Chester			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Odessa Chriswell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 464 22 4748		17. INFORMANT ADDRESS Betty L. Chester Same address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>Subcoronary thrombosis</i> (c) <i>Due to, or as a consequence of</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <i>11/16</i> 19 <i>76</i> to <i>1/16</i> 19 <i>77</i> , that (1) (we) last saw the deceased alive on <i>11/16</i> 19 <i>76</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if true) (did not see the body after death)					
22b. SIGNATURE <i>Dr. Lewis Dennis</i>		DEGREE <i>MD</i>		22c. DATE SIGNED <i>1/17/77</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Lewis Dennis		22e. ADDRESS 831 University Blvd. E. Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 20 Jan 77	23c. NAME OF CEMETERY OR CREMATORY Washington Nat'l Cem. Suitland		23d. LOCATION CITY OR TOWN COUNTY STATE pg Md.	
24. FUNERAL DIRECTOR NAME *** 4308 Suitland Rd, Suitland, Md. 21023		25a. DATE REC'D. BY REGISTRAR JAN 24 1977		25b. REGISTRAR'S SIGNATURE <i>Barbara McCready</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Burial may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

77-02061

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Josephine T. Chevalier</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-21-77</b>			2b. HOUR <b>5<sup>10</sup> P.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-22-88</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASH, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CLERK</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. STORE</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>COLLEGE PARK</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9400-49<sup>th</sup> AVENUE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALPHONSO M. CHEVALIER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELLEN MARY COLLINS</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>578-03-2924</b>		17. INFORMANT ADDRESS <b>ANNA E. SINCLAIR - ITEMS 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 day</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Calcification of Mitral annulus</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>12 Jan</b> , 19 <b>77</b> , to <b>21 Jan</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>21 JAN</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Ira Tublin</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/22/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ira Tublin</b>					22e. ADDRESS <b>8830 Cameron Court, Silver Spring, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/25/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN MAUS.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD-PG-MD.</b>			
24. FUNERAL DIRECTOR NAME <b>W.W. CHAMBERS</b>					ADDRESS <b>RIVERDALE MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1977</b>			
					25b. REGISTRAR'S SIGNATURE <b>Patricia McCready</b>					

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PAGE 10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 77-02062

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH ESTIMATED		XX MONTH DAY YEAR	2b. HOUR
ERNEST		HOWARD	CHILSON	1/26 1977		10:35	P. M.	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	1/26 1977	P. M.
M.	W.	12 8 08	68 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D. C.		U. S. A.		Montgomery		MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park		4 Hickory Avenue		Carpenter.				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
Maryland		Montgomery		Takoma Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		
Howard Chilson.		Ina.		Yes.		W. W. # 2 414-18-6075		
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Self.		(13e)		IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		Years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		None		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
				None		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
		P.M. 19		None				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .		TITLE (SPECIFY) Deputy		DATE SIGNED		1/27/77		
ACTUAL SIGNATURE <i>John S. Rogers</i>		MEDICAL EXAMINER 1919 Seminary Road		SILVER SPRING, MONTGOMERY, MD.				
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		
John S. Rogers, M.D.				Burial.		Feb. 1, 1977		
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE RECEIVED		23f. RECEIVED BY SIGNATURE		
Arlington National		Virginia		FEB 2 1977		<i>Patty McCuskey</i>		
23g. FUNERAL DIRECTOR NAME		23h. FUNERAL HOME		23i. DATE RECEIVED		23j. RECEIVED BY SIGNATURE		
<i>John S. Rogers</i>		2514 Carroll St. DC						



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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

177-02063  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Aljeanna Bertha CLARKE			20. DATE OF DEATH MONTH DAY YEAR January 28, 1977			2b. HOUR 8:45A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 20, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Expediter		12b. KIND OF BUSINESS OR INDUSTRY Westinghouse	
13a. STATE Maryland		13b. COUNTY Pr. George's		13c. CITY OR TOWN Greenbelt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Clarke		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Grant		13e. STREET ADDRESS 428 Ridge Road, # 2			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-14-2790		17. INFORMANT Mrs. Loretta Anderson		ADDRESS 14 G Laurel Hill Rd. Greenbelt, Md. 20770	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> 174X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1/16/77</i> , 19 <i>75</i> , to <i>1/28</i> , 19 <i>77</i> , that (I) (we) lost <i>1/22</i> saw the deceased alive on <i>1/22</i> , 19 <i>77</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.							
21. SIGNATURE <i>Lewis H. Dennis</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/28/77	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, M.D.				22e. ADDRESS 832 University Blvd., East Silver Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-1-77		23c. NAME OF CEMETERY OR CREMATORY Bridgeport Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bridgeport Harrison W. Va.	
24. FUNERAL DIRECTOR NAME ADDRESS Francis Gasch's Sons, P. A. 4739 Baltimore Ave., Hyattsville, Md.				25a. DATE REC'D. BY REGISTRAR JAN 31 1977		25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-22003



Handwritten notes and stamps in the upper section of the document, including a date stamp "11-22-00" and various illegible markings.

Large section of handwritten notes and stamps in the middle of the document, featuring a prominent date stamp "11-22-00" and various illegible markings.

Handwritten notes and stamps in the bottom section of the document, including a date stamp "11-22-00" and various illegible markings.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

Clear with John Ball MD - Medical Examiner.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First JOHN	Middle A.	Last CLINTON	2a. DATE OF DEATH Month 1 Day 3 Year 77			2b. HOUR 4:15 M
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1-26-00		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Russia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH MONTGOMERY Md.			
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Bethesda Retirement & Nursing		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) (Retired) Official		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland 20015		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8700 Jones Mill Road	
14. FATHER'S NAME First Alexis Middle HEJMENTS Last			15. MOTHER'S MAIDEN NAME First Rebecca Middle Bernstein Last			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			
16b. SOCIAL SECURITY NO. 318-07-6035			17. INFORMANT Nephew Robert A. M. Predan, 1101 S. Brainard, LaGrange			Address III 60525			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral respiratory failure</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular d.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Parkinsonian</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (a) (this hospital) attended the deceased from <u>Apr. 19 76</u> , to <u>Jan 19 77</u> , that (a) (we) saw the deceased alive on <u>Dec 24 1976</u> , and that (a) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (b) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James R. Coleman MD</u>		DEGREE JAMES R. COLEMAN		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 1/3/77			
22d. PHYSICIAN'S NAME (Type) JAMES R. COLEMAN		22e. ADDRESS 9241 COLUMBIA BLVD SILVER SPRING MARYLAND 20910							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 1/6/1977		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland Maryland			
24. FUNERAL DIRECTOR JOSEPH GAWLER'S SONS INC. 1130 WISC. AVE. N. W. WASH. D. C. 20016		25a. RECORD REGISTRAR JAN 7 1977		25b. RECORD REGISTRAR [Signature]					

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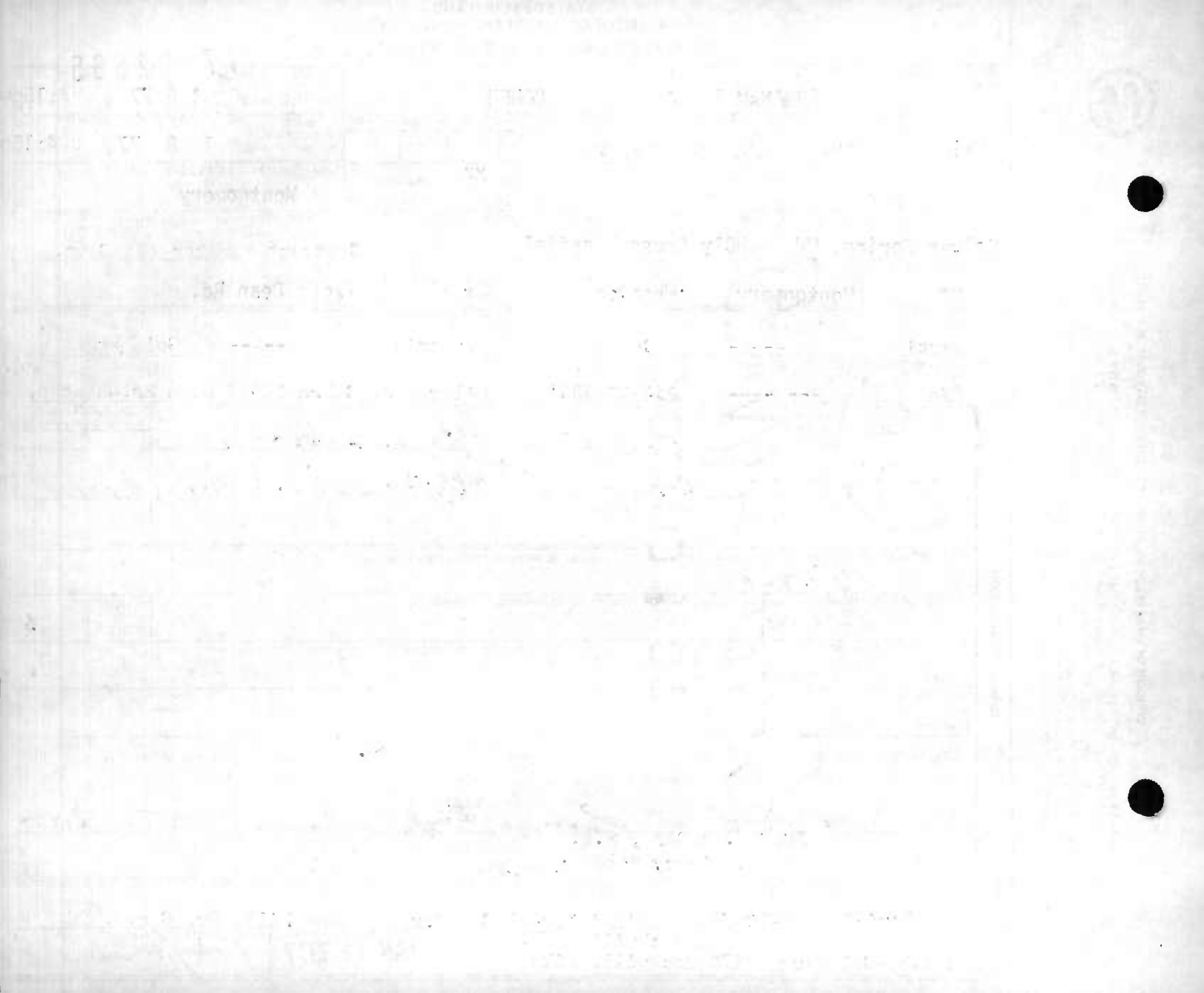
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 707-02065

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST ABRAHAM		MIDDLE J		LAST COHEN		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 1		DAY 8		YEAR 77		2b. HOUR 4:15pm	
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH Feb. 15, 1923		YEAR 53 YRS.		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 24 YRS. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD		2d. HOUR 4:15pm	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery											
10. CITY OR TOWN OF DEATH Sslver Spring, Md		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contract Manager		12b. KIND OF BUSINESS OR INDUSTRY US Govt.			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE MD		13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 12919 Dean Rd.									
14. FATHER'S NAME FIRST Martin						MIDDLE -----						LAST Cohen					
15. MOTHER'S MAIDEN NAME FIRST Beatrice						MIDDLE -----						LAST Goldberg					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 054-20-5851				17. INFORMANT ADDRESS Mildred J. Cohen 12919 Dean Rd, Wheaton, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> 428X } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>chronic myocardial Dis. Ks</u> } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>None</u>																	
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <u>John S. Rogers, M.D.</u>				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER				DATE SIGNED Jan 8, 1976					
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, M.D.				ADDRESS 1919 Seminary Road SSpg, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-10-77		23c. NAME OF CEMETERY OR CREMATORY B'nai Israel Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Oxon Hill, Pr. Geo., Md.							
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg				ADDRESS 1170 Rockville Pike				25a. DATE REC'D. BY REGISTRAR JAN 12 1977				25b. REGISTRAR'S SIGNATURE Anthony McCreedy					



DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201



FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02066

1. DECEASED NAME (TYPE OR PRINT) EVA M CONAWAY			2a. DATE OF DEATH MONTH DAY YEAR 1 31 77			2b. HOUR 11:30 AM			
3. SEX Female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 9 10 1889		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CTY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FERNWOOD HOUSE				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE D.C. 20008			13b. COUNTY Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3133 Conn. Ave., N.W.				
14. FATHER'S NAME FIRST MIDDLE LAST JOHN F CONAWAY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LAURA B FLOYD			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 579-60-3330		
17. INFORMANT Attorney James A. Smith, 1125-15th St., N.W. Wash., DC											

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Insufficiency 4123 (b) Intermittent Heart Disease (c) DUE TO OR AS A CONSEQUENCE OF Chronic Depression		APPROPRIATE INTERVAL BETWEEN CAUSE AND DEATH 1 Day	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from January 19 74 to January 31 19 77, that (I) (we) last saw the deceased alive on Jan 19 19 77, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Initials) (Initials) (Initials) view the body after death.							
22b. SIGNATURE J. Blaine Fitzgerald, M.D.				DEGREE M.D.		22c. DATE SIGNED 1/31/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald, M.D.				22e. ADDRESS 8218 Wisc. Ave., Bethesda, Md. 20014			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/1/1977		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.	
24. FUNERAL DIRECTOR NAME Joseph G. Williams, Inc. 5130 Wisc. Avenue Wash, DC				25a. DATE REC'D. BY REGISTRAR FEB 3 1977		25b. REGISTRAR'S SIGNATURE H. J. McCarty	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02067

1. DECEASED NAME (TYPE OR PRINT) Charles E. Connolly			2a. DATE OF DEATH MONTH DAY YEAR 1 22 77			2b. HOUR 4:30 P.M.			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 5 94		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY I.B.M.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) D.C.		13b. CITY OR TOWN WASHINGTON, D.C.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3925 12th Street, N.E.			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES CONNOLLY			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET BURKE						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 077-05-3646A <del>077-05-3630X</del>		17. INFORMANT NEPHEW		ADDRESS SILVER SPRING, MD. BERNARD FIZPATRICK, 14000 CASTLE BLVD.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute cardiovascular arrest</u> 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic heart disease</u> (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) uremia

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>1/12</u> 19 <u>77</u> to <u>1/22</u> 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Myron L. Lenkw</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/22/77</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MYRON L. LENKW		22e. ADDRESS 2309 SHARFIELD RD WHEATON, MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/25/77		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET		23d. LOCATION WASHINGTON, D.C.	
24. FUNERAL DIRECTOR'S NAME FRANCIS J. COLLINS				ADDRESS 500 UNIV BLVD. W. SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR JAN 26 1977	
						25b. REGISTRAR'S SIGNATURE <u>Robert McQuinn</u>	

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02068

1. DECEASED NAME (TYPE OR PRINT) Marie Mitchell CONNOLLY			2a. DATE OF DEATH MONTH DAY YEAR January 26 1977		2b. HOUR 245 P M	
3 SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 15 1916	6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian/Home maker		12b. KIND OF BUSINESS OR INDUSTRY Military/Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland 13b COUNTY Montgomery 13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4504 Tournay Road	
14. FATHER'S NAME FIRST MIDDLE LAST Jesse W. Mitchell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Brittie Irene Newton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 317-22-7905		17 INFORMANT Husband ADDRESS George I. Connolly Jr. See item 13	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPIRATION PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: (b) <u>INCREASED INTRACRANIAL PRESSURE</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Prob. leptomeningeal CA secondary CA of breast</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I (this hospital) attended the deceased from Dec. 8 1976 to Jan. 26 1977, that (I (we) lost saw the deceased alive on Jan. 26 1977, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.						
22b. SIGNATURE Mark D. Lenger, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Jan. 27, 1977
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark D. Lenger, M.D.				22e. ADDRESS National Naval Medical Center, Bethesda, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1977 Jan. 31,		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.
24. FUNERAL DIRECTOR NAME Jos. Gawler Sons				ADDRESS Washington, D. C.		25a. DATE REC'D. BY REGISTRAR JAN 31 1977
						25b. REGISTRAR'S SIGNATURE Rickey McCready

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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DHMH - 16 60M 1/75  
(VR A 15 (4))1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02069

1. DECEASED NAME (TYPE OR PRINT) <b>Amedeo Jimmie Contrada</b>			2a. DATE OF DEATH MONTH <b>JAN</b> DAY <b>1</b> YEAR <b>1977</b>		2b. HOUR <b>10<sup>40</sup> P.M.</b>
3 SEX <b>MALE</b>	4 RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH <b>JAN</b> DAY <b>8</b> YEAR <b>1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10 CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON HOSPITALIST HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>TAILOR</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>DRY CLEANER</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>P.G. Co.</b>	13c. CITY OR TOWN <b>BERTSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>4224 POWDER MILL RD.</b>
14 FATHER'S NAME FIRST <b>VINCENZO</b> MIDDLE <b></b> LAST <b>CONTRADA</b>			15 MOTHER'S MAIDEN NAME FIRST <b>MARIA</b> MIDDLE <b></b> LAST <b>PUGLIESE</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO.</b>		16b. SOCIAL SECURITY NO. <b>231-10-2249</b>		17 INFORMANT ADDRESS <b>BARBARA A. PARKER SAME AS #13</b>	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> <b>427.2</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF b) <b>—</b> DOE TO, OR AS A CONSEQUENCE OF c) <b>—</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4/1/76</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>—</b>					
19a. DATE OF OPERATION <b>1/1/77</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>—</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>—</b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/6/76</b> , 19 <b>—</b> , to <b>1/1/77</b> , 19 <b>—</b> , that (I) (we) lost saw the deceased alive on <b>1/1/77</b> , 19 <b>—</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/2/76</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OSOTH LEKAGUL MD</b>		22e. ADDRESS <b>8218 Wixamsin Ave, Bethesda, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>1/6/77</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>NORFOLK VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>FLOR LAUREL FUNERAL HOME INC.</b>		25a. DATE REC'D BY REGISTRAR <b>JAN 6 1977</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

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 FOR  
STATE  
REGISTRAR

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 77-02070

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		DATE ESTI- MATED		MONTH		DAY		YEAR		2b. HOUR																					
JAMES		S.		CORKRAN				1-12-		1977								M																					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD						2d. HOUR																					
male		white		Nov. 30, 1937		39 YRS.						1-12-		1977				7:11a																					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH																															
Maryland		U.S.A.		WIDOWED		DIVORCED		Montgomery County										MD.																					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																																	
Silver Spring		Holy Cross Hospital		roads		Montgomery Co.																																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS																															
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		11826 College View Dr.																															
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST																													
Herman		J.		Corkran		Helen				Huber																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																																	
No		212-34-0552		Mrs. Barbara E. Corkran		11826 College View																																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
IMMEDIATE CAUSE (a) <u>Acute tamponade</u>																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																																							
(b) <u>Ruptured dissecting aneurysm of aorta</u>																																							
DUE TO, OR AS A CONSEQUENCE OF																																							
(c)																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?																							
																YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																															
				P.M. 19																																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				CITY OR TOWN				COUNTY				STATE																			
								STREET																															
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																							
ACTUAL SIGNATURE <u>Ann M. Dixon</u>										TITLE (SPECIFY) Assistant MEDICAL EXAMINER										DATE SIGNED 1-13-77																			
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS										111 PennSt.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN				COUNTY				STATE																			
Burial				1-15-1977				Gardens of Faith				Baltimore				Maryland																							
24. FUNERAL DIRECTOR NAME										ADDRESS										25a. DATE REC'D BY REGISTRAR										25b. REGISTRAR'S SIGNATURE									
Leonard J. Ruck, Inc.										5305 Harford Rd. Balto; Md.										JAN 17 1977										<u>Barbara E. Corkran</u>									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02071

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
		Rose Lodge Cosgrove					Jan.	25	1977		9:00 AM
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE		7. UNDER 1 YEAR		IF UNDER 24 HRS			
Female	White	Jan 9 1889		88		MONTHS		DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Conn.	U.S.A.			Montgomery MD.		Chevy Chase		4702 Hunt Ave		Homemaker	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md. 20015		Montgomery		Chevy Chase		YES <input type="checkbox"/> NO <input type="checkbox"/>		4702 Hunt Ave.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
James E. Lodge		Maria Dillon		No		213-50-7076		Son-in-law		John M Jones. Same as item 13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4123 Congestive heart failure				arteriosclerotic coronary heart disease				5 yrs.			
				generalized atherosclerosis				10 yrs.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)		glaucoma									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from		1972		to Jan. 25, 1977		that (I) (the hospital) lost					
saw the deceased alive on Jan. 25, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
Thomas L. Hartman M.D.		M.D.		1/25/77							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
THOMAS L. HARTMAN		3301 NEW MEXICO N.W., D.C.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial		1/28/1977		St. Mary's Cemetery		Rockville, Md.					
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME		JAN 27 1977		Patrick McCreedy							
JOSEPH GAWLER'S SONS INC.											
8130 WISC. AVE. N.W. WASH. D.C. 20015											

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02072

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
KATHLEEN		COSTELLO						JANUARY 21, 1977					9:50 AM		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
FEMALE		WHITE		FEB 27, 1911		65		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH									
IRELAND		U.S.A.				MONTGOMERY								MD.	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
ROCKVILLE		1024 GILBERT ROAD		HOUSEWIFE											
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS							
MD.		MONTGOMERY		ROCKVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1024 GILBERT ROAD							
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST			
OWEN		MUCKAIN				BRIDGET				MUCKAIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS									
NO		557-50-3537T		DAUGHTER		ROCKVILLE, MD. 20851									
				STELLA VANDERGRIFT, 1019 MAPLE AVENUE											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1 DEATH WAS CAUSED BY		IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
1541				Metastatic Carcinoma											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(b)											
				adenocarcinoma - Rectum											
		DUE TO, OR AS A CONSEQUENCE OF		(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				Pulmonary emphysema											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
		HOUR A.M. MONTH DAY YEAR													
		P.M. 19													
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>															
22a. I certify that (I) (this hospital) attended the deceased from		1972		to		1-21		1977		that (I) (we) last saw the deceased alive on		1-4		1977	
														and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED											
D. L. Bucy		MD		1-21-77											
22d. PHYSICIAN NAME (TYPE OR PRINT)		22e. ADDRESS													
D. L. Bucy		809 Veins Mill Rd													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE			
BURIAL		1/24/77		GATE OF HEAVEN		SILVER SPRING				MONT		MD.			
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
FRANCIS J. COLLINS		500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		JAN 26 1977		History McCreedy									

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Marie C Cottrell</b>			2a. DATE OF DEATH MONTH <b>7</b> DAY <b>20</b> YEAR <b>1977</b> HOUR <b>12</b> MIN <b>30</b>		
3. SEX <b>female</b>	4. RACE <b>caucasian</b>	5. DATE OF BIRTH MONTH <b>13</b> DAY <b>1896</b> YEAR	6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>GAITHERSBURG</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>ANTON</b> MIDDLE <b>SOUKUP</b> LAST <b>KREEGER</b>			15. MOTHER'S MAIDEN NAME FIRST <b>CAROLINE</b> MIDDLE <b>KREEGER</b> LAST <b>KREEGER</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>181-32-5457</b>		17. INFORMANT <b>MRS. BETTY LEISHEAR (SAME AS ABOVE)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1538</b> IMMEDIATE CAUSE (a) <b>metastatic Colon Cancer</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> , 19 <b>77</b> , to <b>1/19</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1/19</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE <b>Stephen J. Newman MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/20/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN J. NEWMAN</b>		22e. ADDRESS <b>5411 WEST CEDAR LANE, B ETHESDA, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>	23b. DATE <b>1-21-77</b>	23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>		23d. LOCATION CITY OR TOWN <b>ALEXANDRIA</b> COUNTY <b>VIRGINIA</b> STATE	
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES P/A, MARYLAND</b> ADDRESS <b>ROCKVILLE,</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1977</b> 25b. REGISTRAR'S SIGNATURE <b>Robert A. Pumphrey</b>			

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UNITED STATES

DEPARTMENT

OF COMMERCE

NAVY

OFFICE

NAVY DEPARTMENT, WASHINGTON, D. C.

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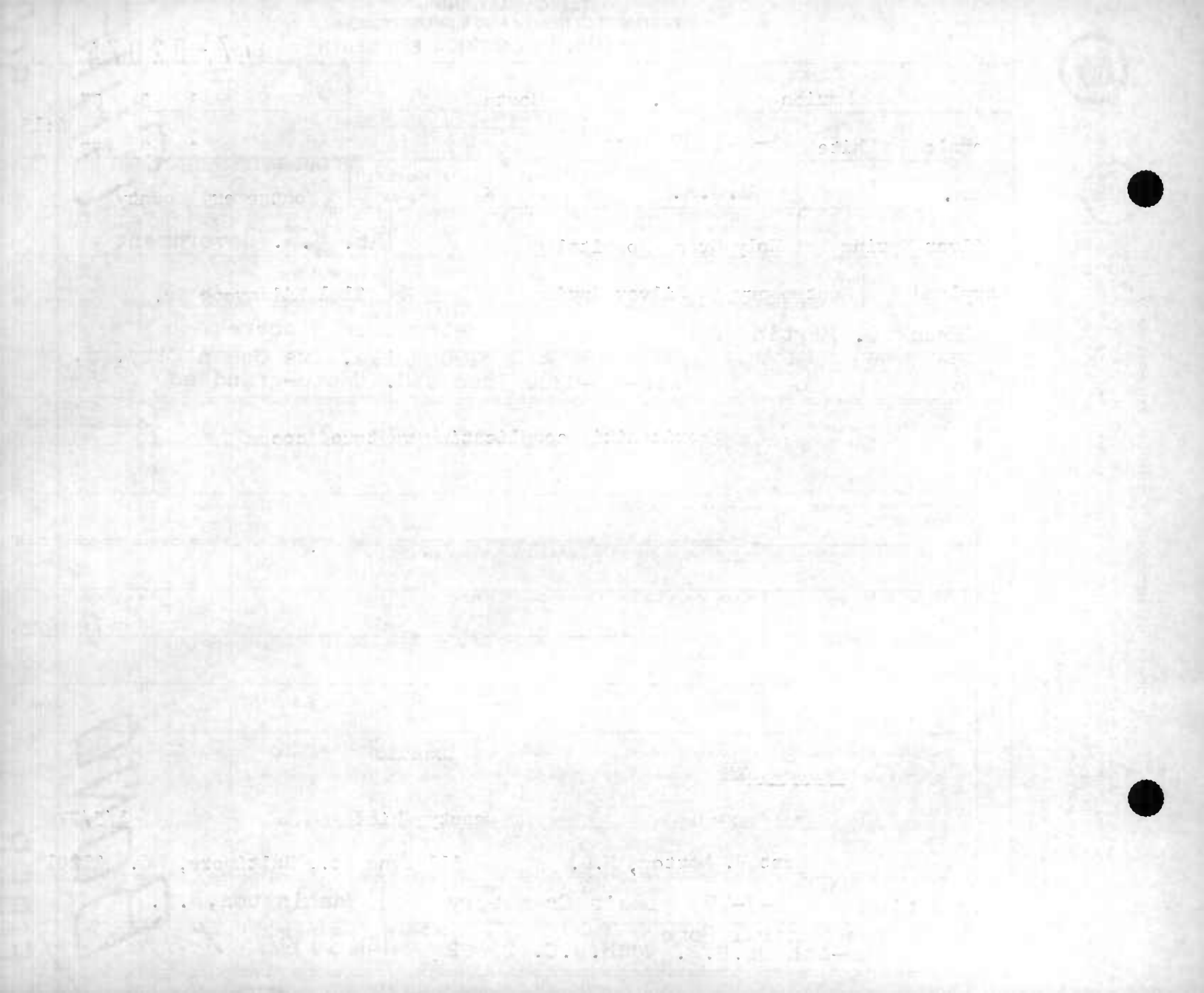
NAVY DEPARTMENT, WASHINGTON, D. C.

NAVY DEPARTMENT, WASHINGTON, D. C.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-1. RETURN PAGE 5 FOR YOUR FILE TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. - 02074			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Marion D. Coutu</b>										2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR <b>1 3 19 77</b>		7b. HOUR <b>4:15</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-4-1907</b>		6. AGE (IN YEARS) (LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>1 3 19 77</b>		2c. DATE PRONOUNCED DEAD <b>1 3 19 77</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Rt. U.S. Government</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>2101 Hildavoee Dr.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank S. Martin</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Petronella Wiocerek</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>448-30-0304</b>		17. DECEASED AT <b>1100 Phila. Ave Ocean City Md.</b> <b>Thomas G. Coutu-grand son 21842</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>5400</b> IMMEDIATE CAUSE (a) <b>Peritonitis complicating ruptured cecum</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <b>Bert F. Morton</b>				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>1/5/77</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Bert F. Morton, M.D.</b>				ADDRESS <b>111 Penn St., Baltimore, Md. 21201</b>									
23a. BURIAL, CREMATION, REMOVAL <b>Cremation</b>				23b. DATE <b>1-7-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION <b>Washington, D.C.</b> COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>Lee Funeral Home</b> <b>300-4th St. N.E. Wash. D.C. 20002</b>						25a. DATE REC'D BY REGISTRAR <b>JAN 10 1977</b>							
25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>													





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02075 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES BRENNAN COX</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>January 18 1977</b>		2b. HOUR <b>4:30 A.M.</b>			
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 29, 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>CHEVY CHASE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4012 LAIRD PLACE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Business Exec.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Oil Company</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN <b>MD. MONTGOMERY CHEVY CHASE</b>		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS <b>4012 LAIRD PL.</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>DANIEL J. COX</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARIE RICE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW 2</b>		17. INFORMANT ADDRESS <b>Marilyn Lee Cox 4012 Laird Pl. Chevy Chase Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1519 IMMEDIATE CAUSE (a) Hypovolemia + Shock</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 years</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>November</b> , 19 <b>74</b> , to <b>January 18</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>January 17</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>CR Gruver MD</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/18/77</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Clifton R. Gruver M.D.</b>				22e. ADDRESS <b>915 19th. st. N.W. Washington D.C.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>ANATOMICAL</b>				23b. DATE <b>1/18/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GEORGETOWN UNIV. MEDICAL SCHOOL, WASH. D.C.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS WASHINGTON, D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>6/1/25/77</b>				25b. REGISTRAR'S SIGNATURE			

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

77-02076

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Harrie E. Craver</b>			2a DATE OF DEATH MONTH DAY YEAR <b>1 19 77</b>			2b HOUR <b>8:55PM</b>				
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Nov. 15, 1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		7 IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10 CITY OR TOWN OF DEATH <b>Olney</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery Gen. Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Dep. Sheriff</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Mont. Co. Gov.</b>		
13a STATE <b>Maryland</b>			13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Brookeville</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>14 High Street</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles Winfield Craver</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Virginia - Myers</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b SOCIAL SECURITY NO. <b>578-10-5382</b>		17 INFORMANT <b>Lillie H. Carver Same as #13</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Myocardial Infarct, multiple</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (c) <b>ASAD</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pulmonary Emboli, CVA</b>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>15 Dec 1976</b> to <b>19 Jan 1977</b> , that (I) (we) last saw the deceased alive on <b>18 Jan 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <b>Daniel L. Anderson</b>						DEGREE <b>MD</b>		22c DATE SIGNED <b>20 Jan 77</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel L. Anderson, M.D.</b>						22e ADDRESS <b>MGH Professional Building, Olney MD 20832</b>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>Jan. 22, 1977</b>		23c NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Olney Mont. Maryland</b>			
24 FUNERAL DIRECTOR NAME <b>Francis H. Barber</b>						ADDRESS <b>Laytonsville, Md. 20760</b>		25a DATE RECD. BY REGISTRAR <b>JAN 24 1977</b>		
						25b REGISTRAR'S SIGNATURE <b>Barry McCreedy</b>				

11-10-77

(M)

out to

11-10-77  
The International Building, 6100 W. 50th St.

Barry J. Robinson, Jr.

#6 g506 +4/77 gj

1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

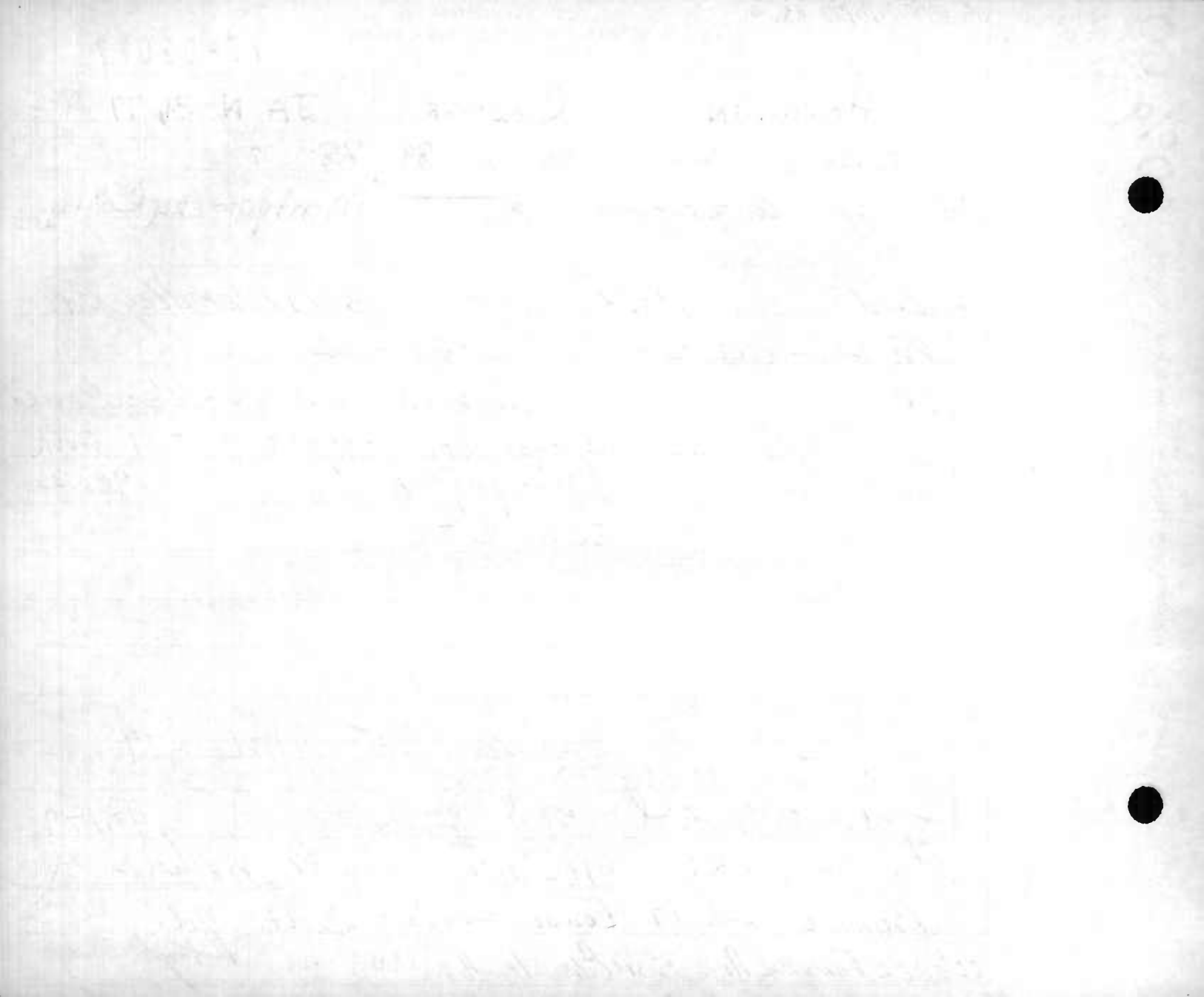
77-02077

1. DECEASED NAME (TYPE OR PRINT) <b>HERMIAN CROMER</b>		2a. DATE OF DEATH MONTH <b>JA</b> DAY <b>N</b> YEAR <b>31, 77</b>		2b. HOUR <b>920 PM</b>
3 SEX <b>FEMALE</b>	4 RACE <b>White</b>	5 DATE OF BIRTH MONTH <b>05</b> DAY <b>30</b> YEAR <b>89</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS <b>87</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>
10 CITY OR TOWN OF DEATH <b>Bethesda, Md.</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE <b>Maryland</b>	13b. COUNTY <b>BALT.</b>	13c. CITY OR TOWN <b>BALT.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>5313 Wendley Rd.</b>
14. FATHER'S NAME <b>Thomas - CROMER</b>		15. MOTHER'S MAIDEN NAME <b>IDA - HAY</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Ruth Cromer</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Accident</b> <b>4109</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost (b) <b>Arteriosclerosis</b> (c) <b>Senility</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week years</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>NOV 25</b> , 19 <b>77</b> , to <b>1/31</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1/31</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.				
22b. SIGNATURE <b>Thos G Ward</b>		22c. DATE SIGNED <b>1/31/77</b>		22d. ADDRESS <b>6116 ROBINWOOD RD, Bethesda Md.</b>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. WARD</b>		22f. ADDRESS <b>6116 ROBINWOOD RD, Bethesda Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>2-3-77</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Louden PARK Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balt. Md.</b>
24. FUNERAL DIRECTOR NAME <b>WEBER FUNERAL Home</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02078  
REG NO

1. DECEASED NAME (TYPE OR PRINT) <b>John Steele Culbertson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-5-77</b>			2b. HOUR <b>5:25 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-23-07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>American USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Director</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>National Fish</b>		
13a. STATE <b>Md.</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John K. Culbertson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Linnie Hart</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>Army WW II</b>		17. INFORMANT ADDRESS <b>Margaret B. --wife--same--</b>			Phone <b>434-7642</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1538</b> IMMEDIATE CAUSE (a) <b>Degetic Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastatic Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ca Colon</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 mos</b> <b>2 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>dehydration - malnutrition</b>										
19a. DATE OF OPERATION <b>May 8, 1975</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca Colon</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <b>7-10</b> , 19 <b>67</b> , to <b>1-5</b> , 19 <b>77</b> , that (1) (we) lost saw the deceased alive on <b>1-5</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>R.H. Sondstrom</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.H. Sondstrom</b>						22e. ADDRESS <b>7701 Carroll Ave, Takoma Park, Md 20012</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>			23b. DATE <b>1/9/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Unity Pres. Church Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodleaf, N.C.</b>		
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home, Inc.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 11 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>		
11800 New Hampshire Ave., Silver Spring, Md.										

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11500 N. Franklin Ave., Suite 200, Chicago, Ill. 60641  
 International Technical School, Inc.  
 11500 N. Franklin Ave., Suite 200, Chicago, Ill. 60641



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit by the funeral director. Pages 1 and 2 should be filed in the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02079	
1 - FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>EDNA PEARL CURRIER</b>						2a. DATE OF DEATH MONTH <b>1</b> DAY <b>1</b> YEAR <b>77</b>		2b. HOUR <b>10:06P</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>16</b> YEAR <b>89</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Govt., Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>D.C.</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>512 Van Buren Street, N.W.</b>	
14. FATHER'S NAME FIRST <b>Francis</b> MIDDLE <b>M.</b> LAST <b>Crossfield</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Alice</b> MIDDLE <b></b> LAST <b>Bunton</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>579-10-4275</b>		17. INFORMANT ADDRESS <b>Mary Lou Cinnamon, Harrodsburg, Kentucky</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
DUE TO, OR AS A CONSEQUENCE OF <b>Myocardial infarction</b>										<b>3 hrs</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b>										<b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <b>August 30 Dec 76</b> , 19 <b>66</b> , to <b>1 Jan 77</b> , 19 <b>77</b> , that (1) (we) lost saw the deceased alive on <b>above</b> , (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John D. Griswold</b> M.D.				DEGREE <b>M.D.</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/1/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John D. Griswold, M.D.</b>				22e. ADDRESS <b>4830 V St. N.W. Washington, D.C./</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1/3/77</b>		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Harrodsburg, Kentucky</b>			
24. FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home, Inc.</b> NAME ADDRESS <b>11800 New Hampshire Ave., Silver Spring, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara McCready</b>			

BP

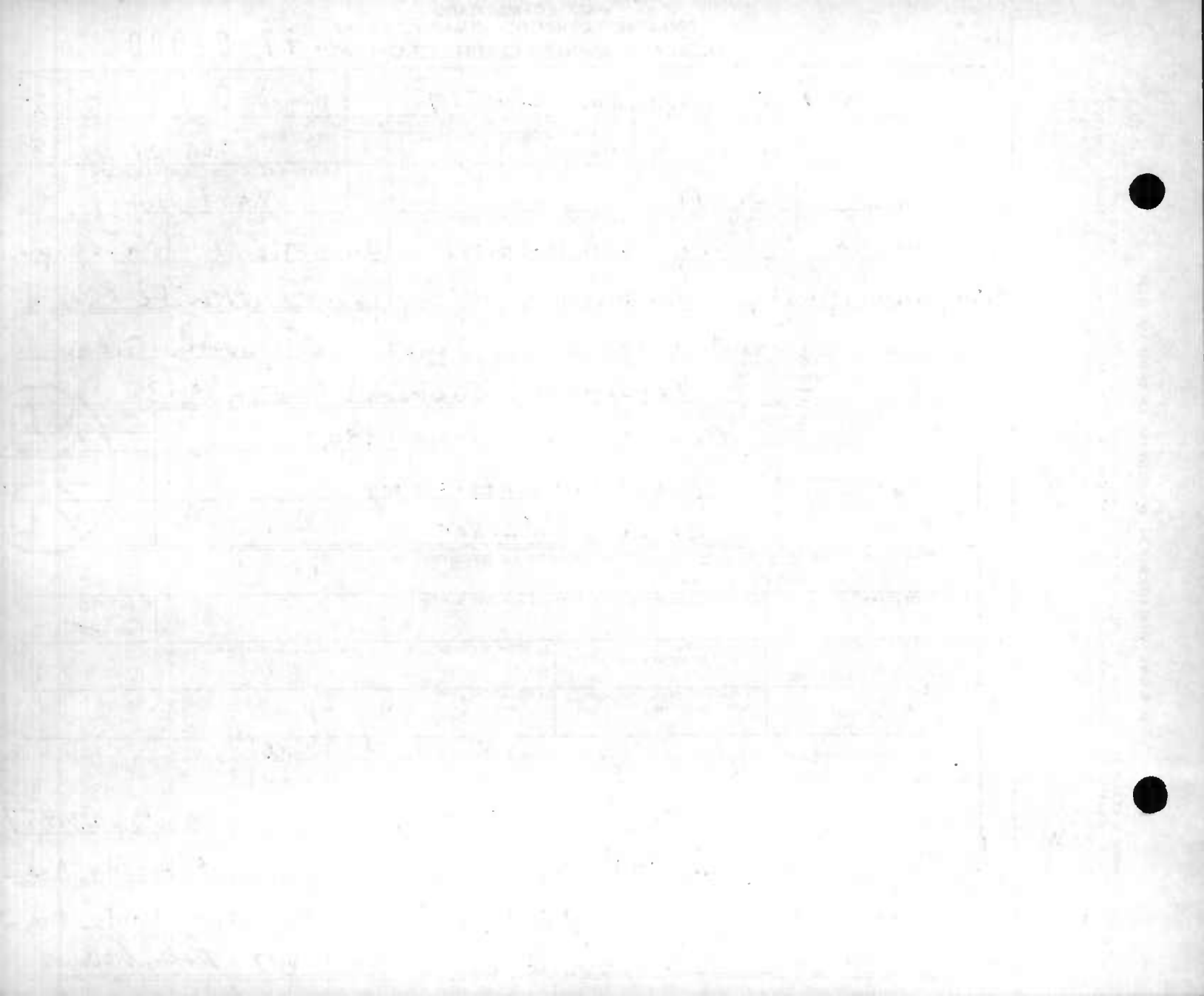


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										77-02080 REG. NO.							
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)										MONTH		DAY		YEAR			
FIRST MIDDLE LAST										1-27		1977		3:45 AM			
Arline Worsham Curtin																	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Fe.		W		11 26 30		46 YRS.		MONTHS		DAYS		Jan. 27 1977		3:45 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED				9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia				U.S.A.				WIDOWED				Montgomery MD.					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda				Suburban Hospital				Advertising				Newspapers					
13a. STATE				13b. CITY OR TOWN				13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS					
Maryland				Montg.				Gaithersburg				YES NO 18205 East Knife Circle					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST				FIRST MIDDLE LAST													
William Bryant Worsham				Janet Elizabeth Greene													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
NO				225-32-5425				Jackson L. Curtin #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Gastro Intestinal Hemorrhage.																	
5710																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b) Hepatic Insufficiency																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c) Cirrhosis of Liver																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
alcoholism -																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY?																	
YES NO				YES NO													
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
P.M. 19																	
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on										Autopsy		Inspection		Inquiry		and in my opinion	
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner																	
ACTUAL SIGNATURE										TITLE (SPECIFY)		DATE SIGNED					
John G. Ball										M.D. Deputy		MEDICAL EXAMINER		Jan 27, 1977			
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS							
John G. Ball MD														Bethesda, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial				1-30-77		Forest Oak Cemetery				Gaithersburg Montg. Md.							
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Fritz A. Sandison				316 E Diamond Ave. Gaithersburg, Md. 20878				FEB 2 1977				Pierney McCreedy					

MEDICAL CERTIFICATION



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02081

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>SARAH MAY DARCEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-29-77</b>		2b. HOUR <b>5:15 PM</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7 29 94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Bethesda, Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bel Pre Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>
13a. STATE <b>Md.</b>			13b. COUNTY <b>Montg.</b>	13c. CITY OR TOWN <b>Bethesda</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph E. Stacks</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Minnie Lee Caywood</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-38-4308T</b>		17. INFORMANT ADDRESS <b>Thelma A. Darcey (Same as 13c)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Perforating Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction 1 day</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Longstanding Arteriosclerosis 3 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Chronic Brain Syndrome Arteriosclerosis</b>					
19a. DATE OF OPERATION <b>1/29/77</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Brain Surgery</b>		19c. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/29/77</b> to <b>1/29/77</b> , that (I) (we) lost saw the deceased alive on <b>1/29/77</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)					
22b. SIGNATURE <b>S. Lyddane</b>		22c. DATE SIGNED <b>1/29/77</b>		22d. ATTENDING <input type="checkbox"/> MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>2-2-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>		24b. ADDRESS <b>Homes, P.A., Bethesda, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1977</b>	
25b. REGISTRAR'S SIGNATURE <b>Petry McCreedy</b>		25c. ADDRESS <b>5530 Wisconsin Ave., Chevy Chase, Md.</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

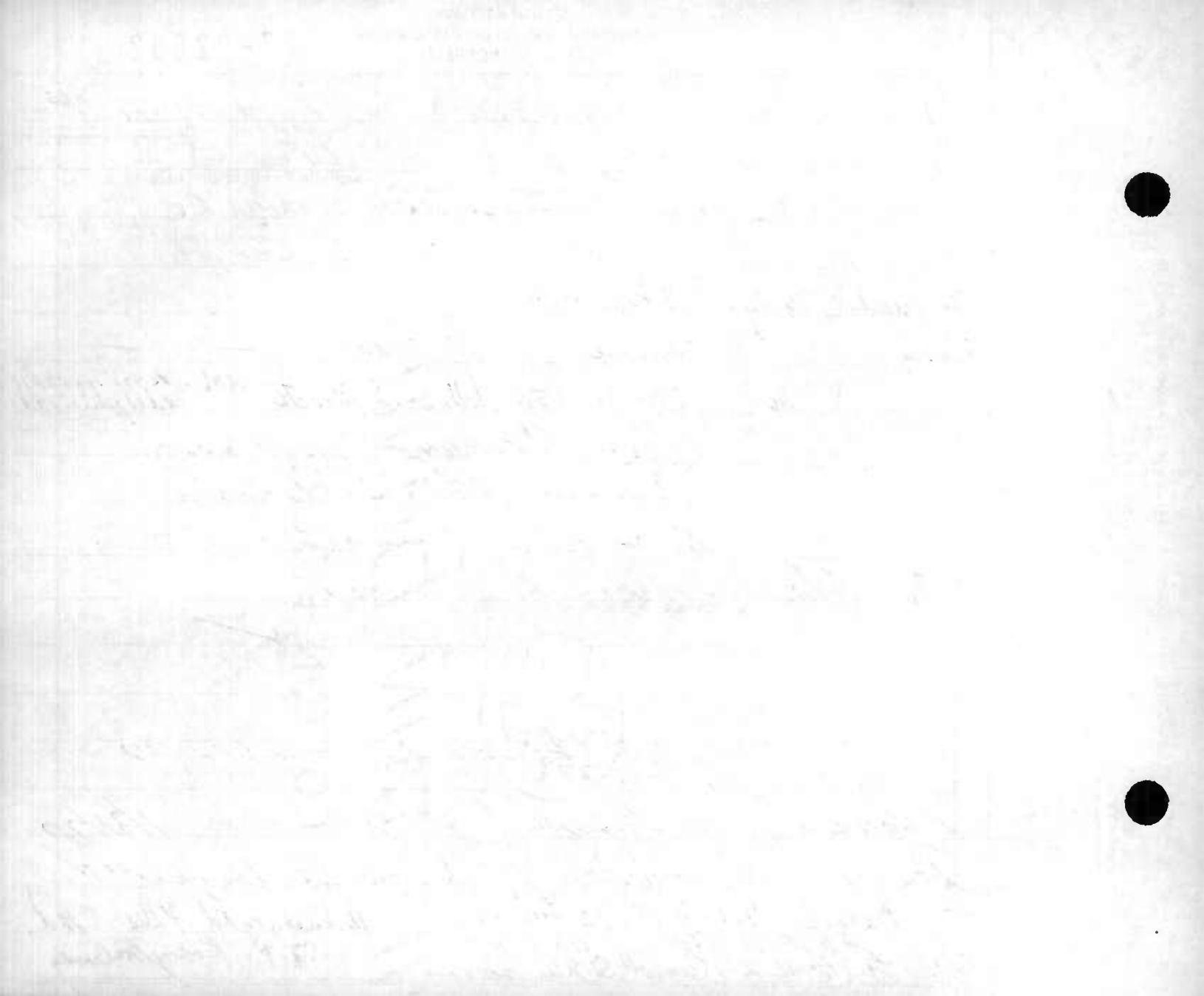
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02082 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Josephine Davidson						2a. DATE OF DEATH MONTH DAY YEAR 1 31 77				2b. HOUR 7:05 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 9 15		6. AGE (IN YEARS LAST BIRTHDAY) 61 yrs.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIAGE STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED		9. BALTIMORE CITY OR COUNTY OF DEATH Montg. Co. MD.					
10. CITY OR TOWN OF DEATH TAKOMA PK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SKI-90 GARDEN NURSING				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Montg.		13c. CITY OR TOWN TAKOMA PK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Maxon						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lyda					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-07-0765H		17. INFORMANT Name H. Maxon, 6. Streets				17b. ADDRESS 1936 - Kermance Rd Adelphi, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Coronary Thrombosis DUE TO OR AS A CONSEQUENCE OF (b) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis, Generalized 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Acute bilateral bronchopneumonia											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1/31/77 to 1/31/77, that (I) (we) lost saw the deceased alive on 1/31/77 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.											
22b. SIGNATURE Howard W. Kennedy, M.D.						DEGREE M.D.		22c. DATE SIGNED 1/31/77			
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Howard W. Kennedy, M.D.						23b. ADDRESS 1111 Spring St. Spring, Md.					
24. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial		25a. DATE Feb. 3, 77		25b. NAME OF CEMETERY OR CREMATORY St. Luke's		25c. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
26. FUNERAL DIRECTOR NAME ADDRESS Arthur Walters, Wash, D.C. Potomac Terr. House, 254 Carroll St. N.W. 20012						27a. DATE REC'D. BY REGISTRAR FEB 7 1977		27b. REGISTRAR'S SIGNATURE H. Maxon			

MEDICAL CERTIFICATION

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FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02083  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth H. P. Davis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-26-77</b>			2b. HOUR <b>4:30 P.M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 22 82</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Manor Care Wheaton Nsg Home</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>1408 Flora Lane</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>William XXXX XXXXXXXXXX Ireland</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Charlotte R Thompson</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>578-62-7205</b>		17. INFORMANT (daughter) ADDRESS <b>Catherine D Butler 1408 Flora Lane Silver Spring, Md</b>		
18. CAUSE OF DEATH (Enter only one cause for Part I. Death was caused by: IMMEDIATE CAUSE (a) <b>Acute Myocardial Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 mos.</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>10/9</b> , 19 <b>76</b> , to <b>1/26</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1/20</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>J. Blaine Fitzgerald</b> DEGREE <b>MD</b>				22c. ADDRESS <b>8218 Wisc. Ave., Bethesda, Md.</b>		22d. DATE SIGNED <b>1/26/77</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 28, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland Prince Georges MD.</b>		
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc., 8434 Ga. Ave., S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>Jan 31 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreary</b>		

MEDICAL CERTIFICATION

2  
X

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Subtotal 100%

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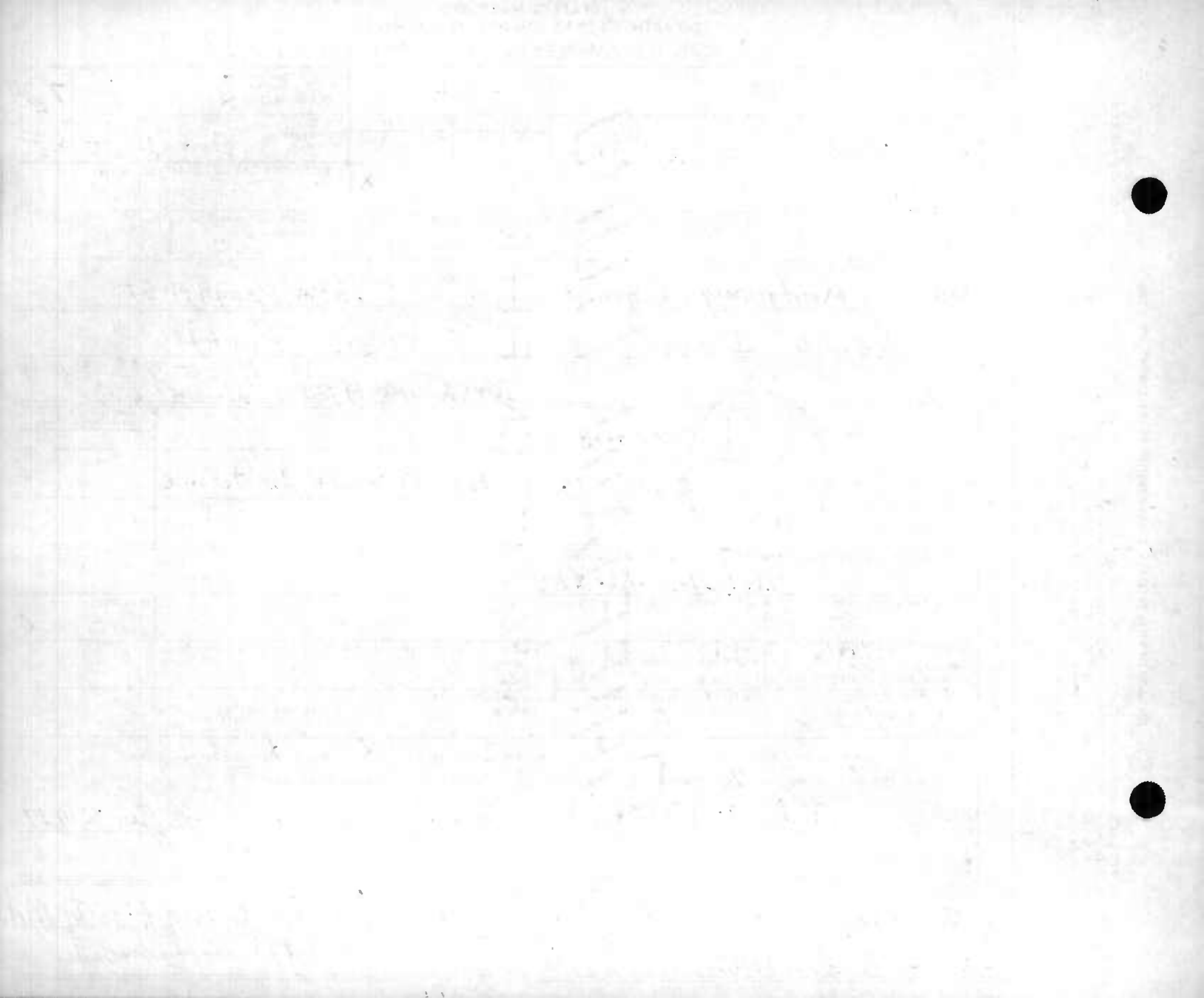
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 77-02084

1. FOR STATE REGISTRAR		20. DATE KNOWN OF DEATH		21. MONTH DAY YEAR		22. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		20. DATE KNOWN OF DEATH		21. MONTH DAY YEAR		22. HOUR	
FIRST MIDDLE LAST		ESTIMATED		1 30 77		9:30 AM	
Lucille Davis		19					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	23. DATE PRONOUNCED DEAD	24. HOUR
Fe.	Black	MONTH DAY YEAR	(LAST BIRTHDAY)	MONTHS DAYS	HOURS MIN.	Jan. 30 1977	8:42 AM
4-26-25	51 YRS.						
70. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	71. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Md.	U.S.A.					Montgomery Co. MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda	Suburban Hospital						
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Md	Montgomery	Kensington	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	10703 Vaughn St.			
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST	FIRST MIDDLE LAST						
Lewis Davis	Rosie Pratt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS			
NO.		Mrs. June Hyson		4235 9th St. N.W. WASH. D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Uremia</u>							
4122							
DUE TO, OR AS A CONSEQUENCE OF							
(b) <u>Cardiovascular Disease, Hypertensive</u>							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
<u>Diabetes Mellitus</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED	
John E. Ball		M.D. Deputy				Jan 30, 1977	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		COUNTY STATE	
Burial	2-2-77	Ash Mem. Cem.		Sandy Spring Montg		Md.	
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
George R. Snowden	246 N. Wash. St. Rockville, Md.		FEB 2 1977		T. J. McCreary		



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

77-02085

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Sarah Walmsley Dean			MONTH DAY YEAR 1 - 12 - 1977			755 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female	White	MONTH DAY YEAR 10 2 95	81 YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Pa.	U.S.A.		MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA	Suburban Hospital			Homemaker				
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
MARYLAND			MONTGOMERY			Chevy Chase		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Fred Walmsley			FIRST MIDDLE LAST Catherine C. O'Byrne					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
No			13-50-7283			A. Catherine Dean (Same as 13e)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>4360</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>8 years</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Coronary heart disease</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			22b. SIGNATURE <u>Dr Joseph P. Kenrick</u>			DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/13/77</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DR JOSEPH P. KENRICK</u>			22e. ADDRESS <u>6450 Wisconsin Ave, Bethesda, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>1-17-77</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Rockville Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Robert A. Pumphrey</u>			24b. ADDRESS <u>Homes, P.A., Bethesda, Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>JAN 17 1977</u>		25b. REGISTRAR'S SIGNATURE <u>Barney McCready</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1-17-77  
St. Louis, Missouri  
St. Louis, Missouri  
St. Louis, Missouri



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02086

1. DECEASED NAME (TYPE OR PRINT) <b>MARY</b>		FIRST		MIDDLE		LAST <b>DECKELBAUM</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1-31-77</b>		2b. HOUR <b>905p</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-15-90</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY CO.</b> MD.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Merchant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Liquor</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1220 Blair Mill Road</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Cune</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Faiga Lapidus</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-09-4344</b>		17. INFORMANT ADDRESS <b>Silver Spring, Md. Philip Deckelbaum 9039 Sligo Creek Pkwy</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sepsis</b> <b>5990</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Urinary tract infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 weeks</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Chronic brain syndrome</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1</b> , 19 <b>77</b> , to <b>Jan 31</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>Jan 31</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.											
22b. SIGNATURE <b>Ronald Bruce Lindmeyer</b> MD						DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/1/77</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald Bruce Lindmeyer</b>						22e. ADDRESS <b>1106 Spring St. Silver Spring Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Bural</b>		23b. DATE <b>2-2-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth Shalom Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>					
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg</b> ADDRESS <b>1170 Rockville Pike</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02087	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary W. DeLay					2a. DATE OF DEATH MONTH DAY YEAR 1 10 1977			2b. HOUR 5:05 P.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 21 1902		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Bookbinder		12b. KIND OF BUSINESS OR INDUSTRY -GPO			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN College Pk.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9014 - Rhode Island Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph White					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia White						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -				16b. SOCIAL SECURITY NO. 578-05-7651		17. INFORMANT ADDRESS Robert E. DeLay - above address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1830 IMMEDIATE CAUSE (a). <i>Carcinomatosis (Husband)</i> DUE TO, OR AS A CONSEQUENCE OF: (b). <i>Ovarian Carcinoma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 ± years</i> <i>2 ± years</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Emphysema, acute hemorrhagic cystitis,</i>											
19a. DATE OF OPERATION <i>July 75</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>NOV 21</i> , 19 <i>75</i> , to <i>JAN 19</i> , 19 <i>77</i> , that (I) (we) lost saw the deceased alive on <i>1/10/77</i> , 19 <i>77</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Frederick Barr, MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>1/11/77</i>			
23a. FATHER'S NAME (TYPE OR PRINT) J. FREDERICK				23b. ADDRESS BARR, MD. 4500 College Ave, College Park, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/14/1977		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.					
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.				ADDRESS Mt. Rainier, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 17 1977		25b. REGISTRAR'S SIGNATURE <i>Jeffrey McCready</i>			

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*[Faint, illegible text lines across the page]*



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG NO 77-02088

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
William M. Donnelly, Sr.								1.10.1977		1		10		19		6:30 PM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	Caus.	12.30.19		57 YRS.						1.10.1977		1		10		19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Pennsylvania		U.S.A.		WIDOWED		DIVORCED		Montgomery									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda		Suburban Hospital		Attorney		U.S. Govt											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Montgomery		Rockville		YES		214 W. Montgomery Avenue									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Charles F. Donnelly		Agnes Martin															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		203 05 7915		Wm. M. Donnelly, Jr. son- same #13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																	
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Coronary Insufficiency Acute.																	
DUE TO, OR AS A CONSEQUENCE OF																	
(b) Cardio Vascular Disease.																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
		STREET, FACTORY, FARM, ETC.)		STREET													
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE SIGNED											
John G. Ball		M.D. Deputy				Jan 10, 1977											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
John G. Ball		7936 Old Georgetown Road, Bethesda															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		1/13/1977		St. Mary's		Rockville, Montg. Md.											
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Tyson Wheeler Funeral Home, Inc.		JAN 17 1977		Bintley McCurdy													
1331 Rockville Pike, Rockville, Md.																	



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02089  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARTIN F. Donchoe		2a. DATE OF DEATH MONTH DAY YEAR 1 15 77		2b. HOUR 10 am
3. SEX MALE	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 6 14 88		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY County MD.
10. CITY OR TOWN OF DEATH Kensington, Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CIRCLE MANOR NH.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager	12b. KIND OF BUSINESS OR INDUSTRY General Elec Co
13a. STATE DC		13b. CITY OR TOWN Washington	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 1517-33 U. St. N. St.
14. FATHER'S NAME FIRST MIDDLE LAST Timothy J. Donchoe		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY O'Toole		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 041-09-3721		17. INFORMANT 17a. Joseph M. P. Donchoe (Brother) 13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2509 IMMEDIATE CAUSE (a) Diabetic Mellitus, Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: Hypertension, diabetes DUE TO, OR AS A CONSEQUENCE OF (b) Disease DUE TO, OR AS A CONSEQUENCE OF (c) Trauma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Hypertension				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21e. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (1) this hospital attended the deceased from Jan 10, 1974, to Jan 15, 1977, that (1) (we) last saw the deceased alive on Jan 13, 1977, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did/did not) view the body after death.				
23a. SIGNATURE Benjamin Arreunin, MD		23b. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23c. DATE SIGNED 1/15/77
23d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin Arreunin, MD		23e. ADDRESS 3720 Foxcroft Ave. Ken Md. 20755		
23f. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23g. DATE Jan 18, 1977	23h. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem		23i. LOCATION CITY OR TOWN COUNTY STATE Washington DC
24. FUNERAL DIRECTOR NAME Robert A. DeLoe	24a. ADDRESS 2222 W. Ave, Washington DC	24b. DATE REC'D. BY REGISTRAR JAN 19 1977		24c. REGISTRAR'S SIGNATURE Pietro Meluschi

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use at the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

Dear Mr. [Name]

I am writing to you

to inform you

that the [Name]

has been [Name]

and the [Name]

has been [Name]

and the [Name]

has been [Name]

and the [Name]

has been [Name]

and the [Name]

has been [Name]

and the [Name]

has been [Name]

and the [Name]

has been [Name]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4900  
VRA 15 (4)  
25m-1/70

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>HENRY</b>		First	Middle	Lost	2a. DATE OF DEATH Month <b>1</b> Day <b>23</b> Year <b>1977</b>		77-02090 7:52 A. M.	
3. SEX <b>M.</b>		4. RACE <b>W.</b>		5. DATE OF BIRTH <b>10/17/08</b>		6. AGE (In years last birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Canada</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>		
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Adventist Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carpenter (Retired)</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Mt. Rainier</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4606 - 29th Street</b>
14. FATHER'S NAME First <b>Marceline</b>		Middle <b>Doucet</b>		Lost <b>Olive</b>		15. MOTHER'S MAIDEN NAME First <b>Aucoyn</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes give war or dates of service) <b>---</b>		16b. SOCIAL SECURITY NO. <b>577-12-2743</b>		17. INFORMANT Address <b>Mrs. Dona Doucet - above address (wife)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>1538</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>chronic myocardial disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Carcinoma of colon</b>								
19a. DATE OF OPERATION <b>1/17/77</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma of colon</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>None</b>				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>None</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>None</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan. 13</b> , 19 <b>77</b> , to <b>Jan 25</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>Jan. 25</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>William H. Ferguson</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNFI <b>1/25/77</b>		
22d. PHYSICIAN'S NAME (Type) <b>William H. Ferguson, M.D.</b>		22e. ADDRESS <b>344 University Boulevard West Silver Spring, Montgomery, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/28/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D. C.</b>		
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home, Inc., Mt. Rainier, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>FEB 15 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or a traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02091 REG. NO.																													
1. DECEASED NAME (TYPE OR PRINT) Ethel E. Dowling										2a. DATE OF DEATH MONTH DAY YEAR 1 5 77 2b. HOUR 1:30 A.M.																													
3. SEX FEMALE					4. RACE White					5. DATE OF BIRTH MONTH DAY YEAR 11 15 1890					6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.					7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland					7b. CITIZEN OF WHAT COUNTRY? U S A					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.																								
10. CITY OR TOWN OF DEATH Rockville					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Nsg. Center										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife					12b. KIND OF BUSINESS OR INDUSTRY																			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.					13c. COUNTY Montgomery					13d. CITY OR TOWN Potomac					13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13f. STREET ADDRESS 9105 Wandering Trail Dr.																			
14. FATHER'S NAME FIRST MIDDLE LAST David L. Harrison					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lelia M. Rockwell										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no										16b. SOCIAL SECURITY NO. 215-50-7800					17. INFORMANT ADDRESS Mrs. Norman L. Morris, 9105 Wandering Tr. Dr.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Acute Cardio-respiratory Collapse Sudden DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary Embolism Sudden DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis many yrs. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b) Bed-ridden; inactivity; Diabetes mellitus										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>																								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																													
22a. I certify that (I) (this hospital) attended the deceased from April 19 76, to 11/5 19 77, that (I) (we) last saw the deceased alive on 10-23-76 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) not view the body after death.										22b. SIGNATURE George H. Mitchell, M.D. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED 11/5/77																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) * George H. Mitchell, M.D.					22e. ADDRESS XXXXX 11125 Rockville Pike Rockville, Maryland 20852																																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial					23b. DATE 1/8/77					23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem					23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.																								
24. FUNERAL DIRECTOR NAME ADDRESS Witzke Catonsville Funeral Home 1630 Edmondson Ave., Baltimore, Md. 21228										25a. DATE REC'D. BY REGISTRAR JAN 7 1977					25b. REGISTRAR'S SIGNATURE F. H. H. H. H.																								

Document

China

Thailand

United States

1945-1946

10000-75  
10000-75

10000-75

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11-02092

1. DECEASED-NAME (Type or print) <b>EMMA G. DREISBACH</b>		First <b>EMMA</b> Middle <b>G.</b> Last <b>DREISBACH</b>		2a. DATE OF DEATH Month <b>1</b> Day <b>1</b> Year <b>77</b>			2b. HOUR <b>10<sup>15</sup> PM</b>		
3. SEX <b>Female</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>12 11 93</b>			6. AGE (In years) last birthday <b>83</b> RS.		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BETH SILESPR. N.Y. RET. CL.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (Where deceased admission) STATE <b>MD.</b>		13b. COUNTY <b>MONT.</b>		13c. CITY OR TOWN <b>CHEVY CHASE</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>7213 ROLLINGWOOD DR.</b>	
14. FATHER'S NAME <b>James Dickey Hester</b>		First <b>James</b> Middle <b>Dickey</b> Last <b>Hester</b>		15. MOTHER'S MAIDEN NAME <b>Mattie May Woodif</b>		First <b>Mattie</b> Middle <b>May</b> Last <b>Woodif</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>109-12-3915</b>		17. INFORMANT <b>Daughter</b> <b>Lois G. Schwoerer.</b> Address <b>Same as item 13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Parkinson's Disease</b> <b>3412X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 YRS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Rheumatoid Arthritis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the <b>hospital</b> ) attended the deceased from <b>Feb</b> , 19 <b>66</b> , to <b>Dec 27</b> , 19 <b>76</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec 27</b> , 19 <b>76</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.									
22b. SIGNATURE <b>Peyton R Evans MD</b>		22c. DATE SIGNED <b>1-1-77</b>		22d. PHYSICIAN'S NAME (Type) <b>PEYTON R EVANS MD</b>				22e. ADDRESS <b>4900 MASS AVE WASH DC 20016</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>1/5/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Easton Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Easton, Pa.</b>			
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SONS, INC.</b> <b>5130 WISCONSIN AVENUE, N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 4 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Parkinson</b>					



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02093  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ARTHUR J. EBERHARD</b>			2a. DATE OF DEATH MONTH <b>I</b> DAY <b>6</b> YEAR <b>77</b>			2b. HOUR <b>2:38</b> M			
3. SEX <b>MASC</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>5</b> YEAR <b>97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b>		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OHIO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Italy Cross Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>md. 13b. COUNTY <b>Mont. Co.</b> 13c. CITY OR TOWN <b>Wheaton</b></b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3004 Henderson Ave. Wheaton, Md.</b>				
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>J.</b> LAST <b>Eberhard</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Emmie</b> MIDDLE <b>Zidler</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>			16b. SOCIAL SECURITY NO. <b>015-05-1158</b>		17. INFORMANT ADDRESS <b>Carl S. Eberhard-son- (same as 13e)</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5-6 days</b> <b>Same</b> <b>Years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR <b></b> A.M. MONTH <b></b> DAY <b></b> YEAR <b>19</b> P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b></b> CITY OR TOWN <b></b> COUNTY <b></b> STATE <b></b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>1-6-77</b> to <b>1-6-77</b> , that (I) (we) lost saw the deceased alive on <b>1-6-77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE <b>Morris Perry</b>			DEGREE <b></b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-6-77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Morris Perry M.D.</b>			22e. ADDRESS <b>11602 Georgia Avenue, Wheaton, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Jan. 7, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		23d. LOCATION CITY OR TOWN <b>Brentwood</b> COUNTY <b>Prince Georges</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR <b>B. Pumphrey, Inc., 8434 Ga. Ave., S.S. Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1977</b>			25b. REGISTRAR'S SIGNATURE <b>P. J. McCreedy</b>			

MEDICAL CERTIFICATION

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X

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires; that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

11-20-1917

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11-20-1917

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02094

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>CLARENCE A. ELLIS</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>3</b> YEAR <b>77</b>			2b. HOUR <b>11:05 AM</b>				
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>02</b> DAY <b>02</b> YEAR <b>1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TENNESSEE</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CHEVY CHASE NURSING &amp; CONV. CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Food Manager (Ret.)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Country Club</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D.C.</b>			13b. COUNTY <b>-</b>		13c. CITY OR TOWN <b>WASHINGTON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5906 13th ST. NW #101</b>	
14. FATHER'S NAME FIRST <b>Wiley</b> MIDDLE LAST <b>Ellis</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Millie</b> MIDDLE LAST <b>Unknown</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>186-07-9712</b>		17. INFORMANT <b>Son</b>		ADDRESS <b>Md. 20016</b>			
					Clarence H. Ellis.		4940 Sentinel Br. Beth.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA AND HEART FAILURE</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 MO</b>	
1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>METASTATIC CARCINOMA, L. IN GUINOL</b> <b>PRIMARY - R - LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (c)									3 MOS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ARTERIOSCLEROTIC HEART DISEASE, CARDIOMEGALY, MITRAL INSUFFICIENCY</b>										
19a. DATE OF OPERATION <b>AUG 1/76</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>METASTATIC CARCINOMA</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>10-29</b> 19 <b>76</b> to <b>1-3</b> 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>12-21</b> 19 <b>76</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Roland Imperial MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-3-77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROLAND IMPERIAL MD</b>						22e. ADDRESS <b>4977 BATTERY LANE BETHESDA MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 5, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Md.</b>		
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS INC.</b>						25a. DATE RECEIVED BY REGISTRAR <b>JAN 5 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				77-02095 REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JAMES B. EVANS</b>				JANUARY 18 1977				745 PM			
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 24, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>BETHESDA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FERNWOOD HOUSE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Executive Agent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Securities Real Estate &amp;</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4515 Willard Ave.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles N. Evans</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clara Barker</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Carmen M. Evans</b>		ADDRESS <b>Same As # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis, generalized</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 years</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> 19 <b>77</b> to <b>1/18</b> 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>1/17</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. E. Fitzgerald</b> DEGREE <b>MD</b>								22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. E. Fitzgerald</b>								22e. ADDRESS <b>3800 Reservoir Rd. NW Wash DC</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/21/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash., D.C.</b>								25a. DATE REC'D BY REGISTRAR <b>JAN 25 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robert M. Crosby</b>	

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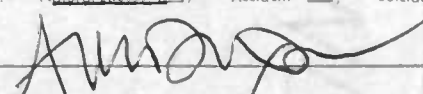
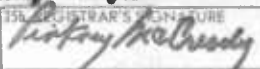
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

77-02096  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>VIVIAN JOANNE FAGG</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1-12-1977</b>			2b. HOUR <b>M</b>		
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 5 1952</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>24</b> YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD <b>1-12-1977 9:15a</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6712 Tupil Hill Terrace</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>6712 Tupil Hill Terrace</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>Alfred E. Fagg</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Doreen Watson</b>		17. INFORMANT <b>Uncle Lawrence W. Fagg</b> ADDRESS <b>Arlington, Virginia 1600 S. Joyce St.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-60-6808</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Seizure disorder</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE 		TITLE (SPECIFY) <b>Assistant</b>		M.D. MEDICAL EXAMINER		DATE SIGNED <b>1-13-77</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>		ADDRESS <b>111 Penn St.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/ 17/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS INC.</b>				25a. DATE REG'D. BY REGISTRAR <b>JAN 24 1977</b>		25b. REGISTRAR'S SIGNATURE 		



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STAGE 21

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02097

1. DECEASED NAME (TYPE OR PRINT) Cora W. Fetrow			2a. DATE OF DEATH MONTH DAY YEAR 1 13 77			2b. HOUR 7 <sup>30</sup> P.M.				
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6 22 1900		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H.W. Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Frederick		13c. CITY OR TOWN Ijamsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 1, Box 142-H	
14. FATHER'S NAME FIRST MIDDLE LAST James Rafter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Wolverton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-74-3985		17. INFORMANT ADDRESS George M. Fetrow, Rt. 1, Ijamsville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4370 IMMEDIATE CAUSE (a) Cerebrovascular insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension, residuals, hemiparesis										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from June 1975, to 1/13 1977, that (I) (X) lost saw the deceased alive on 1/13 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H. Robert Birschbach			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 1/13/77				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Robert Birschbach, M.D.			22e. ADDRESS 10401 Old Georgetown Rd., Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 17, 1977		23c. NAME OF CEMETERY OR CREMATORY Neelsville		23d. LOCATION CITY OR TOWN COUNTY STATE Germantown, Montg., Md.			
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, Damascus, Md.						25a. DATE REC'D. BY REGISTRAR JAN 17 1977		25b. REGISTRAR'S SIGNATURE Dorothy McCready		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02098

1. DECEASED NAME (TYPE OR PRINT) <b>Vernon Paul Finefrock</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-5-77</b>			2b. HOUR <b>10:50<sup>PM</sup></b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 19 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>10 50 00 00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Mont.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. STATE <b>Md.</b>			13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Earl Finefrock</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie E. Bowman</b>			13e. STREET ADDRESS <b>5900 - Sutters Court</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>196-10-6945</b>		17. INFORMANT ADDRESS <b>Mrs. Hazel Finefrock - above address -</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1621</b> IMMEDIATE CAUSE (a) <b>metabolic burglar (wife)</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. DATE SIGNED <b>1/5/77</b>		
22a. I certify that (1) this hospital attended the deceased from <b>12/12/76</b> to <b>1/4/77</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (we) did not view the body after death.									
22b. SIGNATURE <b>Lewis H. Dennis</b>			22c. ADDRESS <b>831-Univ. Blvd. E., Silver Spring,</b>			22d. DATE SIGNED <b>1/5/77</b>			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Lewis H. Dennis</b>			22f. ADDRESS <b>831-Univ. Blvd. E., Silver Spring,</b>			22g. DATE SIGNED <b>1/5/77</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/8/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Conestoga Mem. Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lancaster Lancaster Pa.</b>		
24. FUNERAL DIRECTOR NAME <b>Nalley's F.H. Inc.</b>			ADDRESS <b>1101 Mt. Rainier, Md.</b>		25a. DATE REC'D BY REGISTRAR <b>JAN 11 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McElroy</b>		



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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02099

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>GRACE E. FINK</b>			2a. DATE OF DEATH MONTH <b>JAN.</b> DAY <b>1</b> YEAR <b>1977</b>			2b. HOUR <b>12 P.</b>				
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH <b>MARCH</b> DAY <b>23</b> YEAR <b>1909</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67</b> YRS		7. IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>CHEVY CHASE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4615 N. PARK AVE.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FURNITURE OFFICE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DEPT. STORE</b>		
13a. STATE <b>MD.</b>					13b. COUNTY <b>MONTG.</b>		13c. CITY OR TOWN <b>CHEVY CHASE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>FRED</b> MIDDLE <b>-</b> LAST <b>BURKETT</b>					15. MOTHER'S MAIDEN NAME FIRST <b>LAURA</b> MIDDLE <b>-</b> LAST <b>CLAPPER</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>208-07-1158</b>		17. INFORMANT <b>Daughter</b> <b>BETTY E. DALZELL</b> ADDRESS <b>5211 WYOMING RD. WASH., D.C. 20016</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> <b>4121</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic &amp; hypertensive</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <b>DEC 15, 1976</b> , to <b>JAN 1, 1977</b> , that (1) (we) last saw the deceased alive on <b>DEC 15, 1976</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (we) did not view the body after death.										
22b. SIGNATURE <b>Abraham W. Danish</b> M.D.						22c. DATE SIGNED <b>1/1/77</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ABRAHAM W. DANISH</b>		
22e. ADDRESS <b>1106 SPRING ST. S.S. MD.</b>						22f. DATE SIGNED <b>1/1/77</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>JAN 5, 1977</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS, INC.</b>			24b. ADDRESS <b>5130 WISCONSIN AVENUE, N. W.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 5 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>		

(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examination must be notified at once.

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III



3



1 DECEASED NAME (TYPE OR PRINT) <b>FRIEDA FLEISHMAN</b>			2a DATE OF DEATH MONTH DAY YEAR <b>1 - 3 - 77</b>			2b HOUR <b>2:34 P.M.</b>		
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>11 15 90</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Lithuania</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSP.</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>-----</b>
13a STATE <b>MARYLAND</b>		13b COUNTY <b>MONTGOMERY</b>		13c CITY OR TOWN <b>ROCKVILLE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>6121 Montrose Road</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Mendel ----- Finn</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ruchel ----- unknown</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>-----</b>		17 INFORMANT ADDRESS <b>Jacob J. Fleishman; 9713 Saxony Rd., SSpg, Md</b>				

18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY <b>911X</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
IMMEDIATE CAUSE (a) <b>Sepsis and shock</b>			
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Aspiration</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		24 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (c) -----			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Arteriosclerotic cardiovascular disease + pulmonary edema</b>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (the hospital) attended the deceased from <b>January 3, 1977</b> to <b>January 3, 1977</b> , that (I) (we) lost saw the deceased alive on <b>Jan 3</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Ronald Landman M.D.</b>				DEGREE		22c DATE SIGNED <b>1/3/77</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald Landman M.D.</b>				22e ADDRESS <b>1106 Spring St. Silver Spring Md</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Jan 5, 1977</b>		23c NAME OF CEMETERY OR CREMATORY <b>Ohey Shalom Talmud Torah</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>Danzansky-Goldberg 1170 Rockville Pike</b>				25a DATE REC'D. BY REGISTRAR <b>JAN 11 1977</b>			
				25b REGISTRAR'S SIGNATURE <b>Harvey McCready</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

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Pleased by Dr. Ball  
DIVISION OF VITAL RECORDS, 20 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

M

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO. 77-02101				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emily S. Fox					2a DATE OF DEATH MONTH DAY YEAR 1-17-77			2b HOUR 6:28AM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 2-9-1895		6 AGE (IN YEARS LAST BIRTHDAY) 81		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE VIRGINIA		13b COUNTY LANCASTER		13c CITY OR TOWN KILMARNOCK		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS BOX 626	
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM HENRY SCHROEDER					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GARVIE				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 824-92-1534		17 INFORMANT ADDRESS 11929 LEDGEROCK CT. MURIEL FOX DALLEN POTOMAC, MD. 20854				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1: DEATH WAS CAUSED BY: 4124 IMMEDIATE CAUSE (a) CARDIAC ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiac Disease Years. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic obstructive airways disease.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from December 1976 to January 1977, that (I) (we) last saw the deceased alive on Dec 13 1976, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Harold I. Passes M.D.					DEGREE		22c. DATE SIGNED Jan 17 1977		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD I. PASSES M.D.					22e. ADDRESS 9410 Old Georgetown Road Bethesda Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1-22-77		23c. NAME OF CEMETERY OR CREMATORY FANTINEKILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ELLENVILLE NEW YORK		
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. ROCKVILLE, MARYLAND					25a. DATE REC'D. BY REGISTRAR JAN 24 1977		25b. REGISTRAR'S SIGNATURE [Signature]		

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02102

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOHN K. FRASER			2a. DATE OF DEATH MONTH DAY YEAR 1-14-77			2b. HOUR 9 <sup>10</sup> AM				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 12 9 1885		6. AGE (IN YEARS LAST BIRTHDAY) 91		7. IF UNDER 1 YEAR MONTHS DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont. MD.				
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wash. Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret.-Cabinet		12b. KIND OF BUSINESS OR INDUSTRY Maker-		
13a. STATE Md.			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5112-Flintridge Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST John Fraser			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean ne Knox							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No -			16b. SOCIAL SECURITY NO. 209-10-5008		17. INFORMANT ADDRESS A Mrs. Frances C. Peters-above address.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest, terminal pneumonia 2509 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease 1 day DUE TO, OR AS A CONSEQUENCE OF (c) diabetes mellitus, insulin dependent. years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c): bilateral hip amputee - hyperbolic rhinoid -										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1/11/77, 1977, to 1/14/77, 1977, that (I) (we) last saw the deceased alive on 1/14/77, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE F. W. BRENNWALD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/14/77		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) F. W. BRENNWALD			22e. ADDRESS 831 University Ave. SE Silver Spring Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 1/17/77		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.			
24. FUNERAL DIRECTOR NAME Nalley's F.H. Inc.			ADDRESS Mt. Rainier, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 19 1977		25b. REGISTRAR'S SIGNATURE Henry McCreedy			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02103 REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
ROSE M. FRIED					Jan. 14, 1977					3:30 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Dec. 31, 1892		84		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. USUAL OCCUPATION		11. KIND OF BUSINESS OR INDUSTRY	
Virginia		USA		WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		Montgomery County MD.		Salesperson		Retail	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. CITY OR TOWN	
Chevy Chase		Bethesda Retirement Center		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS		13b. CITY OR TOWN	
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS		13e. CITY OR TOWN		13f. STATE	
Maryland		Montgomery		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1400 East-West Highway		Bethesda		Maryland	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16. WAS DECEASED EVER IN U.S. ARMED FORCES?			
Abraham				Lessye				no			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.				17. INFORMANT			
no				579 12 1834				Alfred S. Fried see # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:										6 months	
IMMEDIATE CAUSE (a) Congestive Heart Failure											
DUE TO, OR AS A CONSEQUENCE OF										18 years	
(b) Hypertension											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Aseptic Meningitis in Nov. 1976											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED			
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				HOUR A.M. MONTH DAY YEAR				(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
(IF EITHER, NOTIFY MEDICAL EXAMINER)				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE			
AT WORK											
22a. I certify that (I) (this hospital) attended the deceased from July 1966 to 1/14/77, that (I) (we) lost											
saw the deceased alive on 1/13/77, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE								DEGREE		22c. DATE SIGNED	
Samuel Dessoiff M.D.								ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/14/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS			
Samuel Dessoiff, M.D.								1302 - 18th St. N.W. Wash., D.C.			
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
Burial				Jan. 16, '77		King David				Falls Church, Fairfax Va.	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
NAME				ADDRESS				JAN 24 1977			
Joseph Gawler's Sons, 5130 Wisconsin Av., NW				Wash. D.C.				Anthony A. Brady			

500-0000

James Taylor's Song, 510 Broadway, N.Y.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02104  
REG. NO.1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Louis - Friedman</b>		2a DATE OF DEATH MONTH DAY YEAR <b>JAN 19 1977</b>		2b HOUR <b>3:45 AM</b>
3 SEX <b>M</b>	4 RACE <b>Cauc</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>05 05 1922</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>54</b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.
10 CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Salesman(Ret)</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Mens Clothing</b>
13a STATE <b>Maryland</b>		13b COUNTY <b>Montg.</b>	13c CITY OR TOWN <b>Sil. Spg.</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Friedman</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Carrie unknown</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>167-28-9667A</b>		17 INFORMANT ADDRESS <b>Rockville, Md.</b> <b>Maxine Hilsberg 11801 Rockville Pike</b>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>7960 IMMEDIATE CAUSE (a) Terminal Respiratory failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/7/77</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Terminal Renal failure</b>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1975</b> , 19____, to <b>1/19/77</b> , 19____, that (I) (we) last saw the deceased alive on <b>1/18/77</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>[Signature]</b> MD		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/19/77</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OSOTH LERAGUL MD</b>		22e. ADDRESS <b>8218 Waverline Cor. Bethesda Rd</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>1-20-77</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Nat'l. Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Virginia</b>
24 FUNERAL DIRECTOR NAME <b>Danza nsky-Goldberg</b>		ADDRESS <b>Rockville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1977</b>
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

40180-11



**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING," IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
15M7/76



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 7 - 02105

FOR 1- STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 77-02105		
1. DECEASED NAME FIRST MIDDLE LAST Mary Beatrice Gainey						2a. DATE OF DEATH KNOWN <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 1 7 19 77		2b. HOUR M P M 3:45
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR June 10, 1927	6. AGE (IN YEARS) (LAST BIRTHDAY) 49 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 7 19 77		7d. P M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland						13b. COUNTY Prince George's		
13c. CITY OR TOWN Laurel						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET ADDRESS 805 West St.								
14. FATHER'S NAME FIRST MIDDLE LAST Robert Johnson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie Carroll				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Lottie Johnson (Mother) same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 5719 IMMEDIATE CAUSE (a) Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Bert F. Morton				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 1/9/77
EXAMINER'S NAME (TYPE OR PRINT) Bert F. Morton, M.D.				ADDRESS 111 Penn St., Baltimore, Md. 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-12-77		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery		23d. LOCATION CITY OR TOWN Jessup, Howard Maryland		
24. FUNERAL DIRECTOR R. Saunders				24b. N. Washington St. Rockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR JAN 13 1977		25b. REGISTRAR'S SIGNATURE H. H. H. H.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG NO. 77-02106

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JNEZ RUTH GAITHER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-17-1977</b>			2b. HOUR <b>4:05 PM</b>			
3 SEX <b>F</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>May 26, 1902</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS		7 IF UNDER 1 YEAR IF UNDER 1 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Advent Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Retired Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>md.</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Beltsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>11540 Old Balto. Pike</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Summerfield Jackson</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Hines</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>R16-38-5442</b>		17. INFORMANT ADDRESS <b>Irving Gaither Rt. 6 - Box 183 Jacobs Rd. Severn md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>174X</b> IMMEDIATE CAUSE (a) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ YES _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11/15 1977</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> 19 <b>77</b> to <b>1/17</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Louis H. Dennis</b>				22c. DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED <b>1/17/77</b>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Louis H. Dennis</b>				23b. ADDRESS <b>Washington Adventist Hospital Takoma Park Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-21-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Rest Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Annapolis Annapolis County Md.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Sanders Funeral Home 217 E. Preston St.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 19 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCurdy</b>	

7402 BP

1890 - 1891

1891 - 1892

1892 - 1893

1893 - 1894

1894 - 1895

1895 - 1896

1896 - 1897

1897 - 1898

1898 - 1899

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1900 - 1901

1901 - 1902

1902 - 1903

1903 - 1904

1904 - 1905

1905 - 1906

1906 - 1907

1907 - 1908

1908 - 1909



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DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		77-02107 REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Daniel V. GALLERY					2a. DATE OF DEATH MONTH DAY YEAR January 16 1977			2b. HOUR 815P M		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR July 10 1901		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia					13b. COUNTY Fairfax		13c. CITY OR TOWN Oakton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Daniel Vincent Gallery					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Onahan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1920-60		17 INFORMANT Mrs. Vera Gallery		ADDRESS See item 13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 5699 IMMEDIATE CAUSE (a) Upper gastrointestinal hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION Jan. 16, 1977		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Upper gastrointestinal bleeding				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Jan. 13, 1977, to Jan. 16, 1977, that (I) (we) last saw the deceased alive on Jan. 16, 1977, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Edwin L. Nerdlinger</i>				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED Jan. 17, 1977		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin L. Nerdlinger, M. D.				22e. ADDRESS National Naval Medical Center, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/21/1977		23c. NAME OF CEMETERY OR CREMATORY Arl. Nat. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.				
24. FUNERAL DIRECTOR NAME Everly Funeral Home				ADDRESS Fairfax, Virginia		25a. DATE REG'D. BY REGISTRAR JAN 18 1977		25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02108

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		MONTHS DAYS HOURS MIN.	
Grace Ellen Garrett		January 20, 1977		1:55 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	75 YRS	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Georgia	USA		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Gaithersburg	215 West Diamond	Housewife	Home		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS		
13a. STATE 13b. COUNTY 13c. CITY OR TOWN		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	215 West Diamond Ave.		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
George M. Pinion		Margaret - Guyton			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-01-9991		Mrs. Dorothy L. Kennedy 2906 Weisman Rd. Wheaton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100 IMMEDIATE CAUSE (a) A.M.I.		Minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) A.S.H.D + H.C. V.D.			
		DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 49 to 1-20 19 77, that (I) lost					
saw the deceased alive on 1-3 19 76, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (each) did not view the body after death.					
21. SIGNATURE		DEGREE		22c. DATE SIGNED	
Jack Schumacher MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1-20-77	
21d. PHYSICIAN'S NAME (TYPE OR PRINT)		22a. ADDRESS			
Jack Schumacher		Russell Ave. Gaithersburg, Md. 20760			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	Jan. 22, 1977	Forest Oak	Gaithersburg, Mont. Md.		
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME Francis H. Barber Laytonsville, Md. 20760		JAN 24 1977		Dorothy McCready	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 77-02109

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR 1977	
William Travis		G		A		T		2a. DATE KNOWN OF DEATH		Jan		3		1977		12 M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	W	7 26 14		62 YRS.						Jan		3		1977		12 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH					
TENNESSEE		U.S.A.										Montgomery		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
SIL SPR		9722 Hedlin Dr.		ACCOUNTANT													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Mont		SIL SPR		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		9722 Hedlin Dr.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
WILLIAM		MINNIE		YES		577-40-3149		EDITH G. GATLIN		SAME AS 13		WIFE					
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST							
WILLIAM		B.		GATLIN				MINNIE		HOWELL							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
955x		Gunshot Wound of Head															
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		None															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
None																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
		10 PM 1 3 1977		Shot self													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
		Home		Hedlin Dr.		SIL SPR		Mont		Md.							
22a. I certify that I took charge of the remains described above, held an death resulted from:		Natural causes <input type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input checked="" type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED		Jan 3, 1977							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
JOHN S. ROGERS		SILVER SPRING, MARYLAND															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
BURIAL		1/5/77		GATE OF HEAVEN		SILVER SPRING		MONT		MD.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
FRANCIS J. COLLINS		500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		JAN 6 1977		Anthony McCready											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02110	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Albert Henry GEIKEN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>January 22, 1977</b>			2b. HOUR p <b>7:45 M</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 16, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>69 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Navy</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Comm. Tech. Retired</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>251 Brock Bridge Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John GEIKEN</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Martha Ackerman</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>					
16b. SOCIAL SECURITY NO. <b>1927-1950</b>			17. INFORMANT <b>Magdalena M. Geiken</b>			ADDRESS <b>251 Brock Bridge Rd, Laurel, Md, 20810</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>450X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Multiple Pulmonary Thromboemboli</b> (c) <b>Multiple Systemic Arterial Thromboemboli</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d) <b>(d) Metastatic Carcinoma of the Colon</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 29, 1976</b> , to <b>January 22, 1977</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 22, 1977</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did not view the body after death.											
22b. SIGNATURE <b>Leo B. Simmons, Jr.</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>23 Jan 1977</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leo B. SIMMONS, Jr. LCDR MSC USNR</b>						22e. ADDRESS <b>National Naval Medical Center Bethesda, Maryland 20014</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan 24 1977</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Ceme.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Arl., Virginia</b>		
24. FUNERAL DIRECTOR NAME <b>Donaldson Funeral Home, 313 Talbot Ave. Laurel, Md. 20810</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1977</b>			25b. REGISTRAR'S SIGNATURE <b>Barney McCready</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>GIUSEPPE A GENTILCORE</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1 20 77</b>		2b. HOUR <b>10:55 A</b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 18 89</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired - stone mason</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>S.S.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>809 Winhall Way.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Philip A. Gentilcore</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosalie S. Brocchi</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579-01-5945</b>		17. INFORMANT ADDRESS <b>Rosalia Policelli, see item #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac-respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary failure. Metabolic acidosis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Recto sigmoid carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>weeks</b> <b>over 3 weeks</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Recto bleeding secondary to above.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 30, 1976</b> to <b>January 22, 1977</b> , that (I) (we) lost saw the deceased alive on <b>January 19, 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Hugo G. Graziani</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-20-77</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HUGO G. GRAZIANI MD</b>				22e. ADDRESS <b>800 Pershing Dr. S.S. Md 20910</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>01-24-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Mont., Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>		11800 New Hampshire		25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem examinations should be reported to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
REG. NO. 77-02112									
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNETTA MARY GERST						2a DATE OF DEATH MONTH DAY YEAR JAN 8 1977		2b HOUR 5:20 P.M.	
3 SEX F		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR NOV 6 1973		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) DC.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10 CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Died at Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Md.						13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST JAMES LAW						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Giachetti			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-58-987		17 INFORMANT NAME AND ADDRESS SARITA GERST Daughter 12521 O'Fallon St S.S.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY 4/23 IMMEDIATE CAUSE (a) Atherosclerosis, Cardiac DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Aortic Aneurysm									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 1976 to Jan 8 1977, that (I) (we) last saw the deceased alive on Dec 31 1976, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L. N. TULIN		DEGREE (MD) ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8 JAN 77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. N. TULIN		22e. ADDRESS 8830 CAMERON ST. SILVER SPRING							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/11/77		23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Wash. D.C.			
24. FUNERAL DIRECTOR NAME Taltavull W.W. 4748 Wisc. Ave. N.W. D.C. 20016				25a. DATE REC'D. BY REGISTRAR JAN 11 1977		25b. REGISTRAR'S SIGNATURE Anthony McCready			

BP



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE		77-02113	
FOR STATE REGISTRAR		JC MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST BERTHA P. GILFILLAN		MONTH DAY YEAR 1-5-77	
3. SEX FEMALE		4. RACE CACAU	
5. DATE OF BIRTH MONTH DAY YEAR 10/21/1898		6. AGE (IN YEARS) LAST BIRTHDAY 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY, MD	
10. CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) 8800 Darnestown Road	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED KENNEL MANAGER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY	
13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 8800 DARNESTOWN ROAD		14. FATHER'S NAME FIRST MIDDLE LAST ALBERT PILKINGTON	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NOT AVAILABLE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO	
16b. SOCIAL SECURITY NO. 579 40 2887		17. INFORMANT 5611 NEW YORK AVENUE OPAL COWAN SARASOTA, FLORIDIA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1538 IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Adeno Carcinoma of colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE JOHN G. BALL M.D.		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)		DATE SIGNED Jan 6, 1977	
23a. BURIAL CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-7-77	
23c. NAME OF CEMETERY OR CREMATORY ROCKVILLE CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MARYLAND	
24. FUNERAL DIRECTOR NAME ROBERT A. BUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND		25a. DATE REG'D. BY REGISTRAR JAN 17 1977	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02114

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENSEL D Gilmer			2a. DATE OF DEATH MONTH DAY YEAR 1 16 77		2b. HOUR 4:15 AM		
3. SEX M		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 20 97		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH 68 Str. Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Embassy Dairy	
13a. STATE 35 Md		13b. COUNTY 10 C.		13c. CITY OR TOWN MT. Rainier		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George G. Gilmer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Davis		13e. STREET ADDRESS 4305 Raywood Dr.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 571-05-6126A		17. INFORMANT Sarah L. Gilmer		ADDRESS 4305 Raywood Dr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2509 IMMEDIATE CAUSE (a) <u>Shallow water pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>diabetes mellitus</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1/6 19 77 to 1/15 19 77, that (I) (we) last saw the deceased alive on 1/14 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph Schanno		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/16/77	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Schanno		23b. ADDRESS 8218 Wisconsin Ave Bethesda Md					
23c. BURIAL (CREMATION, REMOVAL) (TYPE)		23d. DATE Jan-19-77		23e. NAME OF CEMETERY OR CREMATORY George Washington Riggs Pl. P. Res. Md.		23f. LOCATION CITY OR TOWN COUNTY	
24. FUNERAL DIRECTOR Arthur Walters		25. DATE REC'D. BY REGISTRAR AN 19 1977		26. REGISTRAR'S SIGNATURE Henry McCurdy			

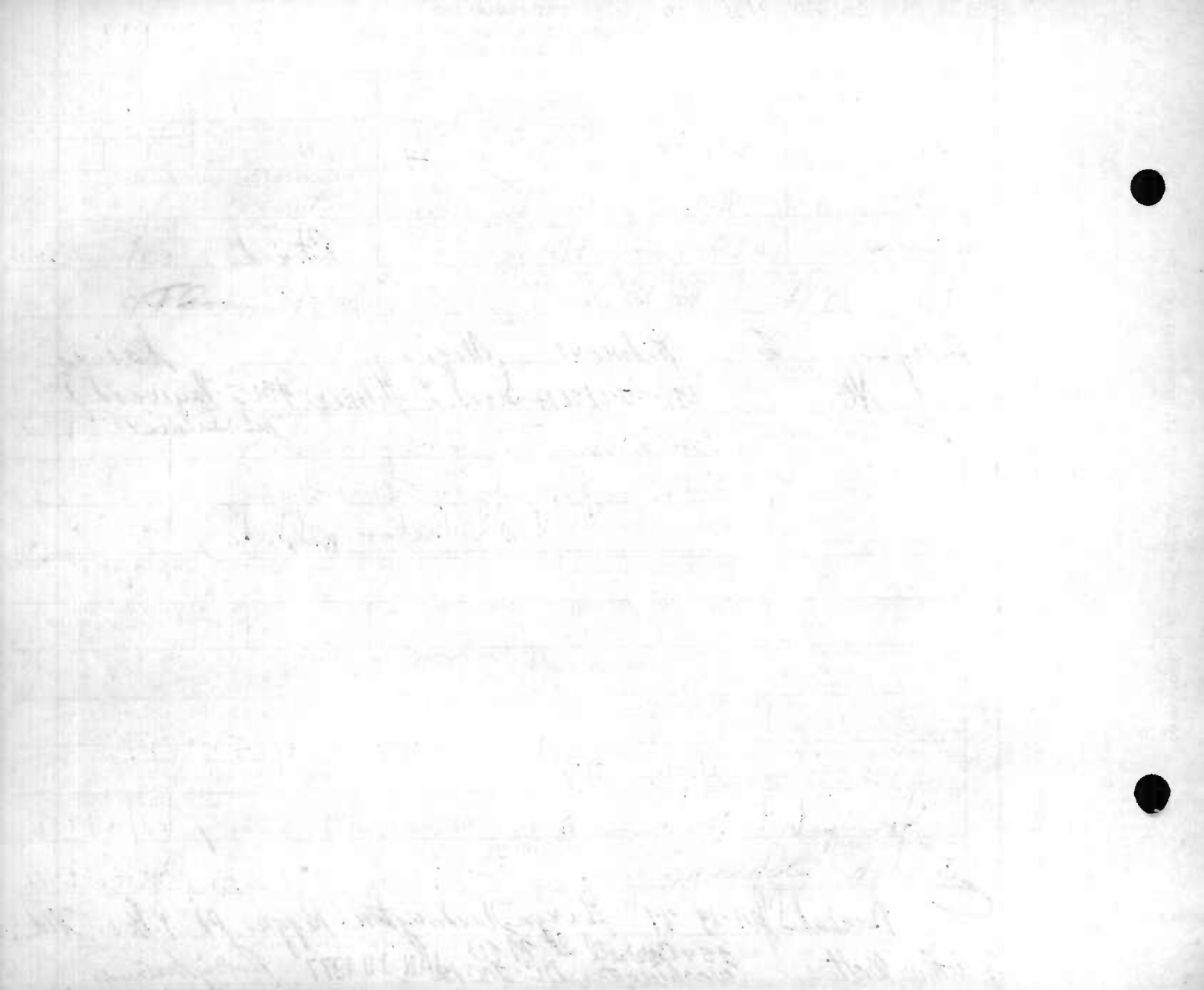
MEDICAL CERTIFICATION

X  
X

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02115

1. DECEASED-NAME (Type or print) First Middle Last <b>ABE Gimble</b>			2a. DATE OF DEATH <b>Jan.</b> Month <b>26</b> Day <b>17</b> Year		2b. HOUR <b>10:50 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>APRIL 15, 1891</b>		6. AGE (In years last birthday) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>MERCHANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>11718 LOVEJOY STREET</b>	
14. FATHER'S NAME First Middle Last <b>SAMUEL GIMBLE</b>	15. MOTHER'S MAIDEN NAME First Middle Last <b>MARY (UNKNOWN)</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>	16b. SOCIAL SECURITY NO. <b>WW 1</b>	17. INFORMANT Address <b>MRS. SELMA GORDON (SAME AS # 13)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gram negative sepsis</b> <b>582X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic renal disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>11/30</b> , 19 <b>77</b> , to <b>1/26</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Myron Lenka</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>1/27/77</b>	
22d. PHYSICIAN'S NAME (Type) <b>MYRON L. LENKA</b>		22e. ADDRESS <b>2809 Shorefield Rd.</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>	23b. DATE <b>1/28/1977</b>	23c. NAME OF CEMETERY OR CREMATORY <b>NATIONAL CAPITAL HEBREW</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR <b>DONALD M. STEIN</b>		ADDRESS <b>232 CARROLL STREET, N.W., WASHINGTON, D. C.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 31 1977</b>	25b. REGISTRAR'S SIGNATURE <b>Patrick McCready</b>

11-10-11

11-10-11

11-10-11

11-10-11

11-10-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be signed and filed within 72 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02116

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Florence M. Giroux</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>January 11, 1977</b>	
3 SEX <b>Female</b>	4 RACE <b>Black</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Jan 30 1887</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Trinidad</b>	7b CITIZEN OF WHAT COUNTRY? <b>West Indies</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Mont.</b>
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, CLINIC, GIVE STREET ADDRESS) <b>8508 16th Street</b>	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Store clerk</b>	12b. KIND OF BUSINESS OR INDUSTRY
13a STATE <b>Md.</b>	13b COUNTY <b>Montgomery</b>	13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13d STREET ADDRESS <b>8508 16th Street</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Francis Giroux</b>	15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Lewis</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b SOCIAL SECURITY NO. <b>None</b>	17 INFORMANT ADDRESS <b>Phyllis Fraser 8508 16th St.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4409</b> IMMEDIATE CAUSE (a) <b>Generalized arteriosclerotic vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Chronic Brain Syndrome</b>			
19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1973</b> , 19____, to <b>1/11/77</b> , 19____, that (I) (we) last saw the deceased alive on <b>11/76</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Jeremy V. Cooke</b>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/11/77</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jeremy V. Cooke</b>	22e. ADDRESS <b>10400 Conn Ave. Kensington Md</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>11/17/77</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	23d. LOCATION CITY OR TOWN STATE <b>St. James Trinidad W. Ind</b>
24. FUNERAL DIRECTOR <b>J.T. Stewart</b>	4001 Benning Road, N.E.		25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1977</b>
		25b. REGISTRAR'S SIGNATURE <b>Patrick McCready</b>	

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1510



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02117

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		ROBERT CARROLL GLISSON		JANUARY 26, 1977		10:15pm	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS	
MALE	CAUCASION	AUGUST 5, 1919	57 YRS	MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
TENNESSEE	U.S.		MONTGOMERY COUNTY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
BETHESDA	NNMC, BETHESDA, MD.		RETIRED		USN		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
TENNESSEE	WEAKLEY	MARTIN	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	326 MOUNT PELIA ROAD			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
JOHN HAYWOOD GLISSON		MARY ELIZABETH CARROLL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES		1940-1960		MRS. FRANCES GLISSON, SAME AS 13			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1709 IMMEDIATE CAUSE (a) OSTEOPGENIC SARCOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Subarachnoid hemorrhage							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from January 17, 1977, to January 26, 1977, that (we) lost saw the deceased alive on January 26, 1977, and that (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (do not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
J. E. MARTIN, M.D.		MD		27 Jan 77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
J. E. MARTIN, M.D.		NNMC, BETHESDA, MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		1-29-77		EASTSIDE CEMETERY		MARTIN WEAKLEY TENN	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Rob't. A. Pumphrey Funeral Home, Bethesda, Md.		JAN 31 1977		[Signature]			

BP

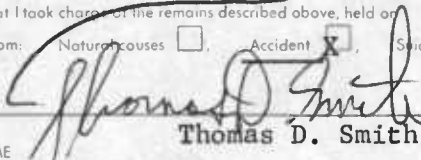
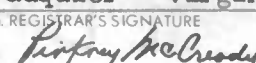
11-22-11



RECEIVED  
JAN 22 1911  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
GENERAL INVESTIGATION  
DIVISION  
RECEIVED  
JAN 22 1911  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
GENERAL INVESTIGATION  
DIVISION



RECEIVED  
JAN 22 1911  
U.S. DEPT. OF AGRICULTURE  
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OFFICE OF THE SECRETARY  
GENERAL INVESTIGATION  
DIVISION  
RECEIVED  
JAN 22 1911  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.  
OFFICE OF THE SECRETARY  
GENERAL INVESTIGATION  
DIVISION

1. DECEASED NAME (TYPE OR PRINT) <b>Jerald</b>		MIDDLE <b>W.</b>		LAST <b>Grant</b>		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>1</b> DAY <b>12</b> YEAR <b>1977</b>		2b. HOUR <b>11:37 P.</b>											
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>1-4</b> DAY <b>19</b> YEAR <b>1942</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>34</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH <b>1</b> DAY <b>12</b> YEAR <b>1977</b>		24. HOUR <b>11:37 P.</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.							
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Architect</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov.</b>							
13a. STATE <b>Va.</b>				13b. COUNTY <b>Fauquier</b>				13c. CITY OR TOWN <b>Catlett</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS <b>216 Overlook Court Rt.2</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>W.</b> LAST <b>Grant</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Juanita</b> MIDDLE <b>M.</b> LAST <b>Cooper</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>				16b. SOCIAL SECURITY NO. <b>098-34-3504</b>				17. INFORMANT ADDRESS <b>Mrs. Ruth C. Grant (wife)</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>9109</b> IMMEDIATE CAUSE (a) <b>Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>9:50 P.M. 1 12 19 77</b>				21b. TIME OF INJURY HOUR <b>9:50</b> P.M. MONTH <b>1</b> DAY <b>12</b> YEAR <b>1977</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>fell into water</b>											
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>water</b>				21f. LOCATION STREET <b>Naval Ship Research</b>		CITY OR TOWN <b>Corderoak</b>		COUNTY <b>Md.</b>		STATE					
22a. I certify that I took charge of the remains described above, held or death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Assistant</b> M.D.				MEDICAL EXAMINER				DATE SIGNED <b>1/14/77</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn St.</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1-16-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Catlett Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Catlett</b>				COUNTY <b>Fauquier</b>		STATE <b>Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Moser Funeral Home, Inc.</b> ADDRESS <b>Warrenton, Va.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1977</b>				25b. REGISTRAR'S SIGNATURE 									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

77-02119

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Harold Henry Greig</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-7-77</b>			2b. HOUR <b>8:30 P.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-13-10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N. Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Service Const. Co.</b>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>717 University Blvd.E.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Greig</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Robina MacLeish</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>194-07-7269</b>			17. INFORMANT <b>Ruth Greig-wife-same-</b>			ADDRESS Phone <b>434-9243</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>5710</b> IMMEDIATE CAUSE (a) <u>Chronic Stroke</u> <u>cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>hepato-renal syndrome</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>curculosis (Kernne's)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-4 hrs</b> <b>1 wk</b> <b>yrs.</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>hepatic encephalopathy</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from <u>1/1/77</u> to <u>1/7/77</u> , that (1) <u>we</u> last saw the deceased alive on <u>1/7/77</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> (did) <u>did not</u> view the body after death.										
22b. SIGNATURE <u>Linda D Smith</u>			DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>1/8/77</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Linda D Smith, M.D.</b>			22e. ADDRESS <b>Washington Adventist Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>11/11/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS INC.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1977</b>			25b. REGISTRAR'S SIGNATURE <u>Pinkney McCready</u>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		77-02120 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST ADDEL		MIDDLE		LAST GRIMMINGER		2a. DATE OF DEATH MONTH DAY YEAR January 4, 1977		2b. HOUR 3:15 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 21 1885		6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nebraska		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 516 Meadow Hall Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - -		17. INFORMANT ADDRESS Virginia Grimminger same as item #13 a-e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Failure</u> 5199 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) <u>Respiratory Infection</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>July 8</u> , 19 <u>76</u> , to <u>Jan 4</u> , 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>Jan 3</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Robert J. Thibadeau</u>		22c. DATE SIGNED 1-4-77				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Thibadeau, M.D.		22e. ADDRESS 11125 Rockville Pike, Rockville, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE XX 1-7-77		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia					
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md 20852		25a. DATE REC'D. BY REGISTRAR JAN 10 1977		25b. REGISTRAR'S SIGNATURE <u>Patricia McCreedy</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02121	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Andrew Gerard Guzulaitis						7a. DATE OF DEATH MONTH DAY YEAR January 11, 1977			7b. HOUR 5:55 A.M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept 21, 1965		6. AGE (IN YEARS LAST BIRTHDAY) 11 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH Md.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5403 Amberwood Lane			
14. FATHER'S NAME FIRST MIDDLE LAST Vylaulas Guzulaitis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Potts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS Vyaulas Guzulaitis, father, same #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudomonas sepsis</u> <u>2040</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute lymphocytic leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days 4 11/12 yrs											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <u>XX</u> (his hospital) attended the deceased from <u>December 30</u> , 19 <u>76</u> , to <u>January 11</u> , 19 <u>77</u> , that <u>XX</u> (we) lost <u>XX</u> (we) (did) <u>view</u> the body after death.											
22b. SIGNATURE <u>Jane Grayson M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/11/77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jane Grayson						22e. ADDRESS of Health, Bethesda, Md. 20014 The Clinical Center, National Institutes					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-14-1977		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland					
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike, Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR JAN 17 1977		25b. REGISTRAR'S SIGNATURE <u>T. J. McCready</u>			

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GENERAL INFORMATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM - 17  
(VR A15 ME (5))  
30M 7/73

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 77-02122	
1. DECEASED NAME (TYPE OR PRINT) <b>Carla Reberholt Haines</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1-31-77		2b. HOUR 2:42 PM			
3. SEX <b>Fe.</b>	4. RACE <b>W.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1-31-1908</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>69</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD <b>Jan. 31 1977</b>		2d. HOUR 2:55 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>19021 Mills Choice Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>19021 Mills Choice Rd</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Oscar B. Reberholt</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Housine C. Christensen</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>578-09-5952</b>		17. INFORMANT ADDRESS <b>802 Darden Drive, Newport News, Va.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Disease -</b> <b>4124</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John G. Ball</b>			TITLE (SPECIFY) <b>Deputy</b>			MEDICAL EXAMINER			DATE SIGNED <b>Jan 31, 1977</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>			ADDRESS <b>1936 old Georgetown, Bethesda, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>2-4-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexanderia Va.</b>			
24. FUNERAL DIRECTOR NAME <b>F.H. Sandison</b>			ADDRESS <b>316 E. Diamond Ave, Gaithersburg, Md. 20860</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1977</b>			25b. REGISTRAR'S SIGNATURE <b>Lutney McCreedy</b>		

17-00122

RECEIVED  
MICHIGAN STATE UNIVERSITY  
LIBRARY

*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "Michigan State University" and "Library" are faintly visible.]*



REG. NO. 77-02123

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RALPH</b>		MIDDLE		LAST <b>HALPER</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>1 23 77</b>		2b. HOUR <b>8 A M</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 15, 1881</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>95</b>		IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebrew Home of Greater Wash.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Counterman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Delicatessen</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1400 Fenwick Lane</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Morris ----- Halper</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie ----- Fier</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No -----</b>					
16b. SOCIAL SECURITY NO. <b>063-03-7715A</b>		17. INFORMANT ADDRESS <b>Ernie Mitzner, Stepson; 5225 Pooks Hill Rd. Bethesda, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 hrs.</b> <b>3 1/2 yrs</b> <b>undetermined</b>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>cerebral arteriosclerosis &amp; transient ischemic attacks, functional tachycardia, angina pectoris</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>2/25</u> , 19 <u>73</u> , to <u>1/23</u> , 19 <u>77</u> , that (I) (we) lost spw. the deceased alive on <u>1/23</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Maurice Franks, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/23/77</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Maurice Franks, M.D.</b>				22e. ADDRESS <b>Rockville, Md. Hebrew Home of Greater Washington</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-25-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>B'nai Israel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Oxon Hill, Pr. Geo. Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Danzansky-Goldberg Chapels 1170 Rockville Pike</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1977</b>		25b. REGISTRAR'S SIGNATURE <u>Dorothy McCreedy</u>					

82450-71

THE NATIONAL ARCHIVES  
COLLECTIONS

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

REG. NO. 77-02124

1 DECEASED NAME (TYPE OR PRINT) <b>BESSIE H. HAMMER</b>			2a DATE OF DEATH MONTH DAY YEAR <b>1 10 77</b>			2b HOUR <b>10:40a</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>6 27 84</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>92</b>		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W.Va.</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>				
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>---</b>		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Washington, D. C.</b>			13b CITY OR TOWN <b>Washington, DC</b>			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13d STREET ADDRESS <b>1717 Ft. Davis Street SE</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>John A. Harman</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Iserna Dove</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No ---</b>				
16b SOCIAL SECURITY NO. <b>578463704</b>			17 INFORMANT ADDRESS <b>Route 1, Box 639 Ralph C. Hammer Stevensville, Md.</b>							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY <b>4109</b> IMMEDIATE CAUSE (a) <b>Cardiac Failure</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b>									<b>1 month</b>	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Dis</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION <b>N/A</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (1) (this hospital) attended the deceased from <b>12/27</b> , 19 <b>76</b> , to <b>1/10</b> , 19 <b>77</b> , that (1) <del>lost</del> lost saw the deceased alive on <b>1/10</b> , 19 <b>77</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (1) <del>viewed</del> did not view the body after death.										
22b SIGNATURE <b>Richard C. Coffi</b>			DEGREE <b>MD</b>			22c. DATE SIGNED <b>1/10/77</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. C. COFFI</b>			22e ADDRESS <b>10620 GG Ave - SS Md</b>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>13Jan77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland PG Md.</b>		
24 FUNERAL DIRECTOR NAME <b>Robert E. Wilhelm Funeral Home</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia A. Brady</b>		
4308 Suitland Rd, Suitland, Md. 20023										

MEDICAL CERTIFICATION

Cleared by M.E. Dr. Rogers 1/10/77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-0113-11

APR 11 1966

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APR 11 1966

APR 11 1966

APR 11 1966

APR 11 1966

APR 11 1966

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 77-02125			
1. FOR STATE REGISTRAR												2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilma C. HARDESTER												ESTIMATED <input checked="" type="checkbox"/> 1-20-77		1977 A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 / 17 / 1900		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD Jan-20-77		2d. HOUR 10 A M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IN SUCH FACILITY, GIVE STREET ADDRESS) 4745 Bradley Blvd. Apt. # 404				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk (Retired)				12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4745 Bradley Blvd. Apt. # 404					
14. FATHER'S NAME FIRST MIDDLE LAST William Cleary						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Nesmith									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT Helen H. Chapman -niece- Savannah, Ga.				ADDRESS 2022 Vermont Ave. 31404					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> 402X Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER Bethesda, MD				DATE SIGNED 1/20/77			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS 7936 Old Georgetown Rd.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment				23b. DATE 1/24/77		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Mausoleum				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood, Prince Georges, Md.					
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons				ADDRESS Washington, D.C. 5130 Wisconsin Ave. N.W.				25a. DATE REC'D. BY REGISTRAR JAN 26 1977				25b. REGISTRAR'S SIGNATURE Dorothy McCrady			

01/2005

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02126	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROBERT I HARDING						2a. DATE OF DEATH MONTH DAY YEAR JANUARY 1, 1977			2b. HOUR 7:45 AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 12, 1904		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co MD					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Mgr.			12b. KIND OF BUSINESS OR INDUSTRY Deli		
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4502 Avondale St.			
14. FATHER'S NAME FIRST MIDDLE LAST Unknown						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-01-3755		17. INFORMANT ADDRESS 8902 Cheltenham Ave. Catherine Gallo Clinton, Md.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY FAILURE</u> <u>150X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CARCINOMA OF ESOPHAGUS</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> <u>3 MONTHS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 19 72</u> to <u>JAN 1 19 77</u> , that (I) (we) lost <u>saw the deceased alive on 12/31 19 76</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Dr. Leo I. Donovan</u>						DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/1/77</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR LEO I DONOVAN						22e. ADDRESS 8218 WISCONSIN AVE BETHESDA MD					
23a. BURIAL, CREMATION, REMOVAL (PRECISE) Entombment		23b. DATE Jan. 4, 1977		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Maus.			23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg, Md.				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Md.						25a. DATE JAN 5 1977		25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey			

MEDICAL CERTIFICATION

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4801 BP SP

17-52188

270-1-52188  
JACKSON, W. J.  
JACKSON, W. J.

Information  
JACKSON, W. J.  
JACKSON, W. J.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 77-02127					
1. DECEASED NAME (TYPE OR PRINT) <b>IRENE HARRIS</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>January 21, 1977</b>					2b. HOUR <b>11<sup>00</sup> A.M.</b>
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 9, 1906</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Chevy Chase</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda Ret. &amp; Convalescence Ctr.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>C.I.A.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>District of Columbia</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Washington</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4000 Cathedral Ave. NW</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elmer Harris</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Landis</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT ADDRESS <b>Richard Harris (nephew) 471 Theresa Dr. Bolder, Col. 80303</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>174X</b> IMMEDIATE CAUSE (a) <b>shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Breast cancer</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>2 years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>2/19/75</b> , 19 <b>75</b> , to <b>1/21</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>1/10</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Aron Primack M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/21/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Aron Primack, M. D.</b>				22e. ADDRESS <b>106 Irving St. N. W. Washington, D. C.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial/ Removal</b>		23b. DATE <b>1/22/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Leon Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Leon Iowa</b>				
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>				

[illegible]

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**QUESTIONS**

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Released by Dr. Ball

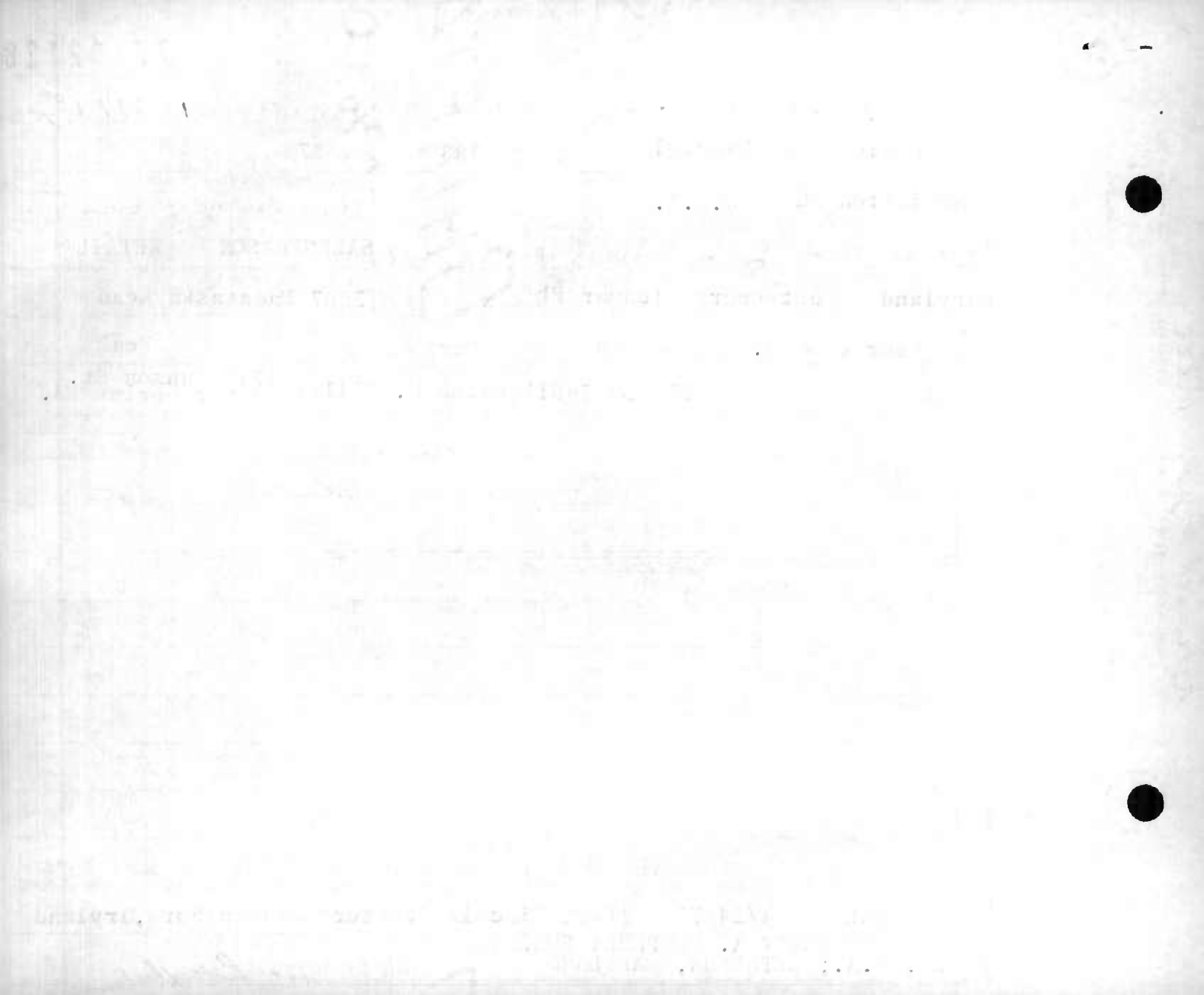
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02128
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) Mary Louise Heines					2a. DATE OF DEATH MONTH DAY YEAR January 21, 1977					2b. HOUR 1:00 PM
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 14 1889		6. AGE (IN YEARS LAST BIRTHDAY) 87		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK, TEST, BUSINESS, OR PASTIME) SALESPERSON		12b. KIND OF BUSINESS OR INDUSTRY RETAIL				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Glenmar Pk		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5907 Madawaska Road		
14. FATHER'S NAME FIRST MIDDLE LAST George M. Hayden					15. MOTHER'S MAIDEN NAME FIRST MIDDLE Mary Peak					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578 30 7091		17. INFORMANT ADDRESS Joseph H. Miller 2713 Munson St. Silver Spring Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY 403X IMMEDIATE CAUSE (a) Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic nephrosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) 2 months 2 yrs										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chemia										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 3-3-77 to 1-21-77, that (I) (we) lost saw the deceased alive on 1-20-77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Stephen W. DeJeter, M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-21-77		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN W. DEJETER, M.D.				22e. ADDRESS 6719 Wilson Rd, Bethesda, Md. 20834						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/24/77		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bladensburg Maryland				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY FUNERAL HOMES, P.A.; BETHESDA, MARYLAND				25a. DATE REC'D. BY REGISTRAR JAN 26 1977		25b. REGISTRAR'S SIGNATURE [Signature]				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 47-02129	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EMMA GERTRUDE HEINRICH										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1/29 1977	2b. HOUR M 8:10
3. SEX F.	4. RACE W.	5. DATE OF BIRTH MONTH DAY YEAR 11 9 1880	6. AGE (IN YEARS) (LAST BIRTHDAY) 96 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD 1/29 1977	7d. HOUR P. M.	7e. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 622 Gist Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Dept. of Commerce.		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 622 Gist Avenue							
14. FATHER'S NAME FIRST MIDDLE LAST Carl H. Heinrich.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Louisa Young.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.			16b. SOCIAL SECURITY NO. 577-30-2549		17. INFORMANT Self.		ADDRESS 13 e.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) Deputy		MEDICAL EXAMINER		DATE SIGNED 1/29/77				
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.			ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 3, 1977		23c. NAME OF CEMETERY OR CREMATORY Glenwood.		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D. C.				
24. FUNERAL DIRECTOR <i>Arthur Walters</i>			25a. DATE RECEIVED BY REGISTRAR FEB 7 1977		25b. REGISTRAR'S SIGNATURE <i>Henry McCready</i>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

M

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02130  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
<del>JOSEPHINE</del> JOSEPHINE - HELBERT					1-5-77					3:07 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	White		Aug 11, 1890		86 YRS.		MONTHS		DAYS		HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
TENNESSEE	U.S.A.				MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Rockville	Collingwood NURSING CENTER		Housewife		OWN HOME						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
13b. STATE		FAIRFAX		FAIRFAX		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4033 DORFORTH DRIVE			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
EMMANUEL		ELIZA		NO		223-36-5717-D		MRS. EDGAR BURTON		4033 DORFORTH DR. FAIRFAX, VA.	
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)		19. IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF		19. DUE TO, OR AS A CONSEQUENCE OF		19. DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4339		Thrombotic cerebral thrombosis		—		—		—		years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from		1975		19		to 1/5/77		19		that (I) (we) lost	
saw the deceased alive on 12/27		1976		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
OSOTH LEKAGUL, MD		MD		1/5/77							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE SIGNED		22g. REGISTRAR'S SIGNATURE					
OSOTH LEKAGUL, MD		8218 Wmerson Ave, Bethesda, Md		JAN 10 1977		History McCreedy					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
REMOVAL-BURIAL		1/5/77		CHESTNUT GROVE		HERNDON, FAIRFAX, VA.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
GREEN FUNERAL HOME, Herndon, VA.				JAN 10 1977		History McCreedy					

BP







TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 77-02131									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
CELIA						HERMAN		JAN 18 1977		4:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		CAUCASIAN		10-10-00		76					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Russia		USA				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
90 WHEATON		RANDOLPH HILLS NURSING HOME						Housewife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
47 D.C.						Washington				1313 N. Capitol Street, N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Samuel		Bassin		Sarah		Unk.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
no		unknown		Silver Spring, Md. Dr. Monte Herman 1401 Blair Mill Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROTIC HEART DIS. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 1 mo	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CEREBROVASCULAR DISEASE											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 65 to 18 Jan 19 77, that (I) (we) last saw the deceased alive on 17 JAN 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
IRA N. TUBLIN, M.D.		M.D.				18 JAN 77					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
		8830 Cameron St., Silver Spring, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		1/18/77		Ohev Sholom Talmud Tor.		Wash. D.C.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Danzansky-Goldberg		Rockville, Md.		JAN 21 1977		P. Kelly McCreedy					
1170 Rockville Pike											

BP



12/1/51

COMMUNICATIONS SECTION

TO : DIRECTOR, FBI (100-371011)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 12/1/51

CLASSIFICATION: [Illegible]

100-371011

100-100000

100-100000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02132 REG. NO.			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Arthur R. HEWETT						2a. DATE OF DEATH MONTH DAY YEAR January 11 1977				2b. HOUR 510A M			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 22 1904		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Navy Retired		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Delaware Kent Dover						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D. 4, Box 715					
14. FATHER'S NAME FIRST MIDDLE LAST Lennox Hewett						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Bennett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 1920 241 44 5819		17. INFORMANT ADDRESS Mrs. Mary M. Hewett See item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 3579 IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Muscular weakness</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Severe peripheral neuropathy - ? cause</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH c 1 minute			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION Dec 8 1976				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Muscle, nerve, artery biopsy				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from Nov. 29 1976 to Jan. 11 1977, that (1) (we) last saw the deceased alive on Jan. 11 1977, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.													
22b. SIGNATURE Bruce A. Hartwig MD						DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Jan. 11, 1977			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce A Hartwig MD						22e. ADDRESS National Naval Medical Center, Bethesda, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan 15, 1977		23c. NAME OF CEMETERY OR CREMATORY Oddfellow's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Camden Delaware					
24. FUNERAL DIRECTOR NAME Harvey S. Siskelson						ADDRESS Federal Building		25a. DATE REC'D. BY REGISTRAR JAN 18 1977		25b. REGISTRAR'S SIGNATURE Anthony McCready			

77-02130

RECEIVED - 1964  
JAN 14 1964  
FBI - NEW YORK

TO : DIRECTOR, FBI (100-388610)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 1/14/64

BY: [Illegible]

100-100000-100

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02133

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Regina AGNES Hines</b>			2a DATE OF DEATH MONTH DAY YEAR <b>January 8, 1977</b>			2b HOUR <b>12:50 p.m.</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>April 20, 1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10 CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens Nursing Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife,</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		
13a STATE <b>Maryland</b>			13b COUNTY <b>Montgomery,</b>		13c CITY OR TOWN <b>Kensington,</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>3000 McComas Ave.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>James -- Halloran</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Cecelia -- Bevans</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No,</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS <b>District Hts. Md.</b> <b>Mr. James W. Hines, 2214 Wintergreen Ave. S.E.</b>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse</b> <b>5990</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>genitourinary tract infection</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immed</b> <b>3 days</b> <b>months</b>
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PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic brain syndrome + generalized arteriosclerosis</b>			
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>

21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE
22a I certify that (I) (this hospital) attended the deceased from <b>Oct 27</b> 19 <b>77</b> to <b>Nov 8</b> 19 <b>77</b> that (I) (we) last saw the deceased alive on <b>Jan 3</b> 19 <b>77</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		

22b SIGNATURE <b>W.R. Ehrmantraut MD</b>	DEGREE <b>MD</b>	22c DATE SIGNED <b>1/8/77</b>
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>W.R. Ehrmantraut MD</b>	22e ADDRESS <b>11125 Rockville Pk, Rockville Md</b>	

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>1/11/77</b>	23c NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Frostburg, Allegany Maryland</b>
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24 FUNERAL DIRECTOR NAME <b>H. Wayne George</b>	24b ADDRESS <b>202 Greene St. Cumberland, Md.</b>	25a DATE REC'D. BY REGISTRAR <b>JAN 12 1977</b>	25b REGISTRAR'S SIGNATURE <b>Dorothy McCready</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For a death occurring in a hospital or nursing home, the death certificate should be completed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1. FOR  
STATE  
REGISTRAR

REG. NO. 77-02134

1. DECEASED NAME (TYPE OR PRINT) <b>Ruth - Hobson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 19 77</b>			2b. HOUR <b>8 AM</b>				
3. SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 16 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>University Hsg Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD</b>			13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>WASHINGTON D.C.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1460 Euclid St. N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Sappero</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susie BARETT</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>NOT STATED</b>		17. INFORMANT ADDRESS <b>CARL HOBSON 6916 8th St N.W. WASH D.C.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Circulatory Failure</b> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Bilateral Hemiplegia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>24 hours</b> <b>14 Months</b>		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Pseudobulbar paralysis 2° stroke, Hypertension and Diabetes mell</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>5-11-1976</b> to <b>1-19-1976</b> , that (I) (we) last saw the deceased alive on <b>1-14-77</b> at <b>8 PM</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Sumaria Rishi</b>			DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-19-77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1-25-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LAPOWES MD</b>			
24. FUNERAL DIRECTOR NAME <b>Watson F. H. Inc.</b>			ADDRESS <b>3435 14th St NW</b>		25a. DATE REC'D BY REGISTRAR <b>JAN 26 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>			

MEDICAL CERTIFICATION

X

X

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

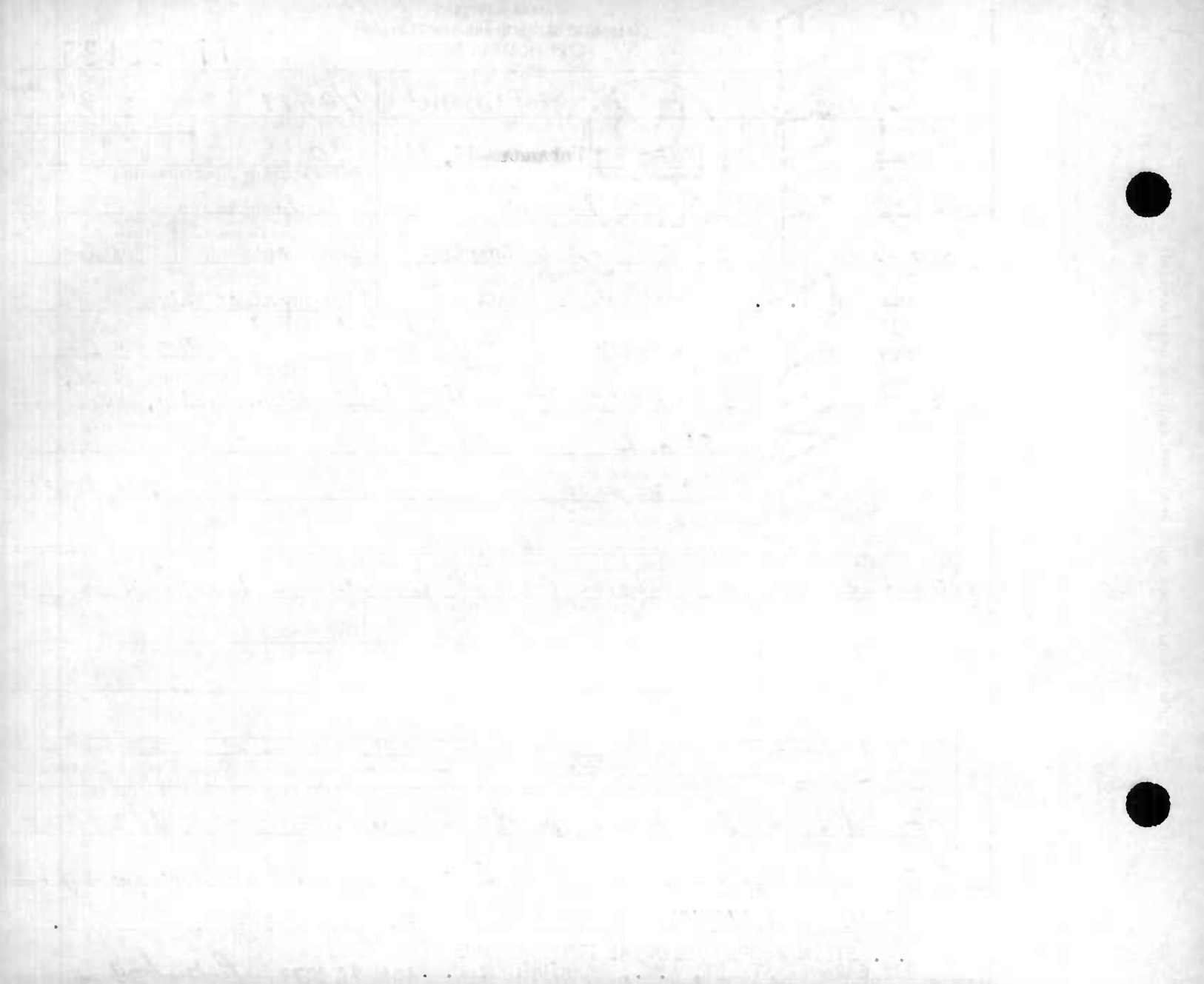
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02135

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FANNIE HOPSMAN			2a. DATE OF DEATH MONTH DAY YEAR 1/21/77			2b. HOUR 9:10 AM					
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR February 15, 1886		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) POLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress			12b. KIND OF BUSINESS OR INDUSTRY Clothing		
13a. STATE Maryland			13b. COUNTY P. G.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1400 Merrimac Drive		
14. FATHER'S NAME FIRST MIDDLE LAST C. Herman BAER M. Mostow				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TAMARA TOVELE				16. ADDRESS 11451 Lockwood Drive, Silver Spring, Maryland			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-62-5025		17. INFORMANT Tillie Chidakel					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock 0399 DUE TO, OR AS A CONSEQUENCE OF (b) ? Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 hrs 24 hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic brain syndrome, Gall bladder disease, heart failure											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from Jan 20, 1977, to Jan 21, 1977, that (1) (two) lost saw the deceased alive on Jan 20, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (two) (did) (do not) view the body after death.											
22b. SIGNATURE Ronald L. London M.D.						DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/21/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ronald L. London M.D.						22e. ADDRESS 1106 Spring St. Silver Spring Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/23/77		23c. NAME OF CEMETERY OR CREMATORY OHEV SHOLOM TALMUD TORAH CONGREGATION			23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON D. C.			
24. FUNERAL DIRECTOR NAME D.M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.						25a. DATE REC'D. BY REGISTRAR JAN 24 1977		25b. REGISTRAR'S SIGNATURE Ruthy K. [Signature]			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02136

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>WALTER N HOFFMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 28 77</b>			2b. HOUR <b>5:35 PM</b>				
3. SEX <b>M</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 11 00</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Madison, Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10. CITY OR TOWN OF DEATH <b>SILVERSPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Auto. Painter Specialist</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11809 Charles Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert T. Hoffman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edith Lowe</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				
16b. SOCIAL SECURITY NO. <b>577-10-7951</b>			17. INFORMANT ADDRESS <b>Mrs Blanche A. Hoffman 11809 Charles Rd. Wheaton, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b> <b>5 years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Emphysema</b>										
19a. DATE OF OPERATION <b>1977</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Emphysema</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>July 1, 1972</b> to <b>July 28, 1977</b> , that (we) last saw the deceased alive on <b>July 28, 1977</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did not) view the body after death.										
22b. SIGNATURE <b>Michael R. Dobridsman</b>			22c. DEGREE <b>M.D.</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <b>July 28, 1977</b>		
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michael R. Dobridsman</b>			22g. ADDRESS <b>13975 Connecticut Ave Silver Spring</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2/1/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Sayle A. Blum</b>			ADDRESS <b>3901 N. Fairfax Arlington, Va.</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>		

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

X  
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02137

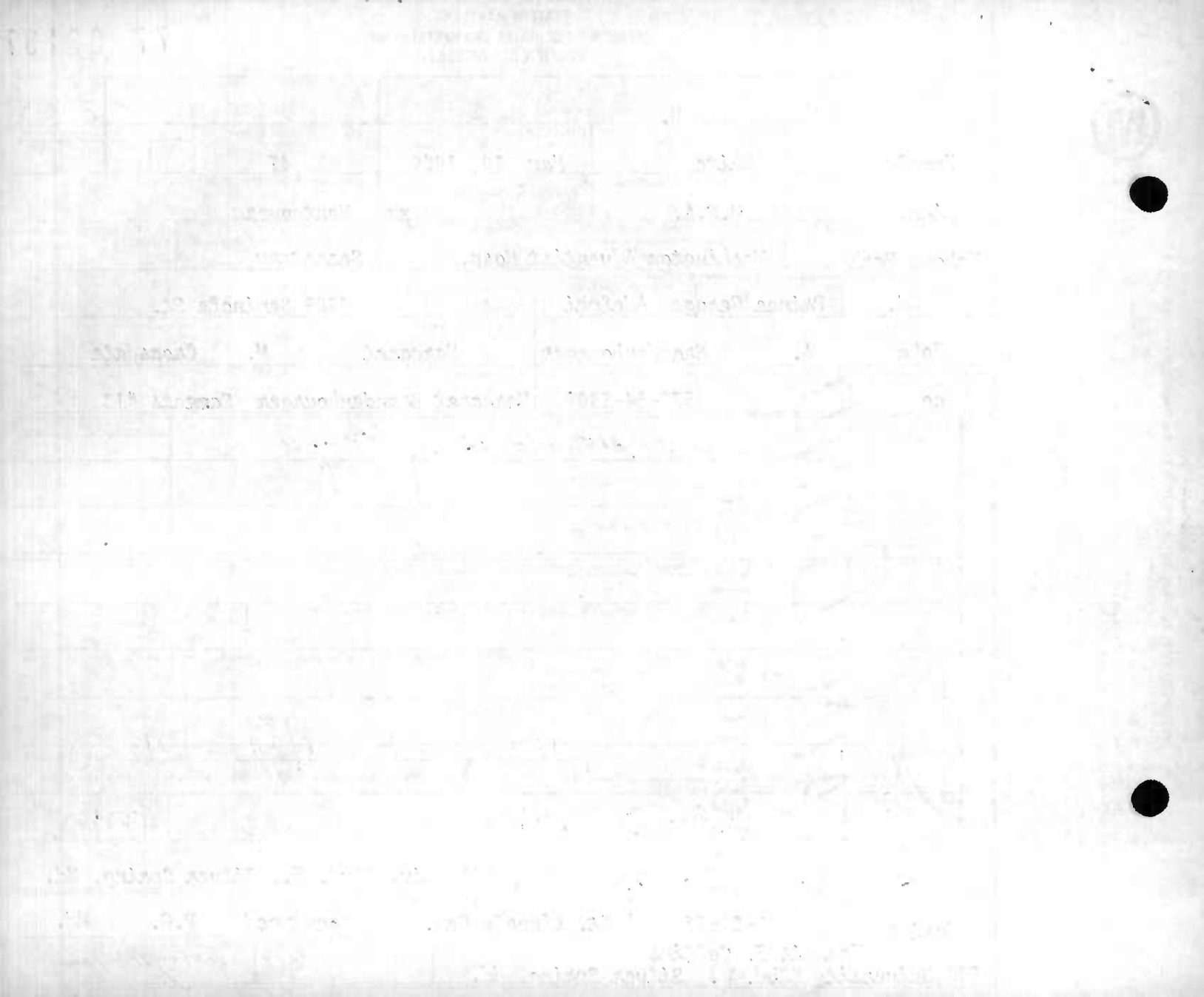
1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alberta M. Holbrook			2a. DATE OF DEATH MONTH DAY YEAR 1 27 77			2b. HOUR 8:40 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 10, 1929		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Prince George		13c. CITY OR TOWN Adelphi	
14. FATHER'S NAME FIRST MIDDLE LAST John A. Brandenbourger				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret M. Croasdale			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-34-2809		17. INFORMANT ADDRESS Margaret Brandenbourger Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1419 DUE TO, OR AS A CONSEQUENCE OF (b) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>myocardial infarction</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/19</u> , 19 <u>76</u> , to <u>1/27</u> , 19 <u>77</u> , that (I) (we) lost <u>1/27</u> saw the deceased alive on <u>1/27</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Lewis H. Dennis</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/27/77</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEWIS H. DENNIS		22e. ADDRESS 831 Univ. Blvd. E., Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-29-77		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.	
24. FUNERAL DIRECTOR NAME Francis J. Collins				25a. DATE REC'D. BY REGISTRAR FEB 3 1977		25b. REGISTRAR'S SIGNATURE <i>Robert M. Brady</i>	
500 University Blvd. W., Silver Spring, Md.							

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02138

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ruth SMITH Hopkins</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>16</b> YEAR <b>77</b>			2b. HOUR <b>10:45 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>14</b> YEAR <b>93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSE WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a. STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4201 Cathedral Ave. 20006</b>	
14. FATHER'S NAME <b>RALPH</b>			15. MOTHER'S MAIDEN NAME <b>EMMA LOUISE Birch</b>			ADDRESS <b>320 MANSION DR. ALEX. VA. 22302</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>LIANNE HOPKINS CONGER, ALEX. VA. 22302</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4380 IMMEDIATE CAUSE (a) cardiac arrest -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <b>Left hemiplegia with coma &amp; hyperthermia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertensive -</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 1/4 hrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Status post Right hemiplegia (years) -</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>12/11/76</b> to <b>1/16/77</b> , that (I) (we) last saw the deceased alive on <b>1/16/77</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>F. W. BRENNWALD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>1/16/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F. W. BRENNWALD</b>				22e. ADDRESS <b>831 University Blvd E Silver Spring Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL/REMOVED</b>		23b. DATE <b>1-18-1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FOREST LAWN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>LOS ANGELES - CAL.</b>			
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS INC.</b>				25a. DATE RECD. BY REGISTRAR <b>2/20/77</b>		25b. REGISTRAR'S SIGNATURE			

BP





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02139

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>William C. Houck</b>			2a. DATE OF DEATH MONTH <b>11</b> DAY <b>7</b> YEAR <b>1977</b>			2b. HOUR <b>9:33</b> AM				
3. SEX <b>Male</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH <b>April</b> DAY <b>20</b> YEAR <b>1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS		IF UNDER 1 YEAR MONTHS <b>73</b> DAYS <b>73</b> HOURS <b>73</b> MIN <b>73</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Contractor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>Washington D.C.</b>			13c. STREET ADDRESS <b>2732 Rittenhouse St. N.W.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Henry</b> MIDDLE <b>Fletcher</b> LAST <b>Houck</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Julia</b> MIDDLE <b>Black</b> LAST <b>Black</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>577-26-0598</b>			17. INFORMANT ADDRESS <b>Catherine M. Houck wife Item # 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC CORONARY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>MYOCARDIAL INFARCTION, OLD</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>HYPERTENSION</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>1/6/77</b> , 19 <b>77</b> , to <b>1/7/77</b> , 19 <b>77</b> , that (I) (the) last saw the deceased alive on <b>1/6/77</b> , 19 <b>77</b> , and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>James P. Ronan</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/7/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES RONAN</b>						22e. ADDRESS <b>7600 Carroll Ave. Takoma Park, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/10/77</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			23d. LOCATION CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Montgomery</b> STATE <b>Md.</b>	
24. FUNERAL DIRECTOR'S NAME <b>JOSEPH GAWLER'S SONS INC.</b>						25a. DATE REG'D. BY REGISTRAR <b>JAN 13 1977</b>				
25b. ADDRESS <b>5130 WISC. AVE., N. W. WASH., D. C. 20016</b>						25c. REGISTRAR'S SIGNATURE <b>Barry J. Brady</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02140

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Raymond C Hough Sr.</b>			2a DATE OF DEATH MONTH DAY YEAR <b>JAN 29 77</b>		2b HOUR <b>845p</b> M
3 SEX <b>M</b>	4 RACE <b>W</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>1 26 96</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PA</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a CITY OR TOWN OF DEATH <b>Silver Spring</b>			9b BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>			11a NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		11b USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Accountant</b>
12a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>			13b CITY OR TOWN <b>Prince Geo.</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Harry Edgar Hough Sr.</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude Greenawalt</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>212-09-0069</b>		17 INFORMANT <b>Bessye H. Smith</b> Same as 13 <b>Daughter</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>486x DILATERAL PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>1976 1/29 77</b>	
22a I certify that (I) (this hospital) attended the deceased from <b>1/29 77</b> to <b>1/29 77</b> , that (I) (we) last saw the deceased alive on <b>1/29 77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b SIGNATURE <b>Joel Gooz</b>		DEGREE <b>MD</b>		22c DATE SIGNED <b>1/30/77</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOEL GOOZ</b>		22e ADDRESS <b>4701 RANDOLPH RD #105 ROCKVILLE, MD 20852</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>2/1/77</b>		23c NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>					
24 FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>		ADDRESS <b>500 Univ. Blvd. W., Silver Spring, Md. 20901</b>		25a REG. D. BY REGISTRAR <b>1/31/77</b>	

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02141

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>YEON TSAI HOUNG</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan 30 1977</b>		2b. HOUR MIN. <b>12 45 A M</b>		
3. SEX <b>MALE</b>		4. RACE <b>Oriental</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 23 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <b>57</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Taiwan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Taiwan</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
13a. STATE <b>Md. 20852</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		13e. STREET ADDRESS <b>12006 Galena Road</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Yu Lan Lii Daughter. Same as item 13.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> <b>4309</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>29 Jan</b> 19 <b>77</b> , to <b>30 Jan</b> 19 <b>77</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>29 Jan</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Horace W. Bernton</b>				DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/30/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Horace W. Bernton, M.D.</b>				22e. ADDRESS <b>4743 Bradley Blvd., Chevy Chase, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>Feb. 4, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Taiwan Formosa</b>	
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS INC.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1977</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 77-02142

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
WILLIAM ERNEST HOUSTON		1/30/77		5:05 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
M.	W.	4 30 18	58 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Tenn		U.S.A.		Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Silver Spring		937 Bonifant Street, #4		Retired	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Montgomery		Silver Spring	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
Unknown		Unknown		Yes	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>None</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>None</u>	
Laura J Johnson, 15805 Paramount Lane		Bowie Md.			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
None					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
		None		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19		None	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
John S. Rogers, M.D.		Deputy		1/31/77	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		1919 Seminary Road Silver Spring, Montgomery, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		2/3/77		Ft Lincoln Cem	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
K. Hunteemann & Son		FEB 7 1977		History McCreedy	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02143

1. DECEASED NAME (TYPE OR PRINT) <b>EVERETT NMN HUDGINS</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>10</b> YEAR <b>77</b> 7b. HOUR <b>9 40 AM</b>		
3 SEX <b>M</b>	4 RACE <b>B</b>	5 DATE OF BIRTH MONTH <b>8</b> DAY <b>25</b> YEAR <b>11</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Pa.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Washington Adventist</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PLUMBER</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D.C.</b> 13b. COUNTY <b>Washington</b>			13c. STREET ADDRESS <b>945 Randolph St., N.W.</b>		
14 FATHER'S NAME FIRST <b>UNKNOWN.</b> MIDDLE <b>UNKNOWN.</b> LAST <b>UNKNOWN.</b>			15. MOTHER'S MAIDEN NAME FIRST <b>UNKNOWN.</b> MIDDLE <b>UNKNOWN.</b> LAST <b>UNKNOWN.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO.		17 INFORMANT <b>Hospital Records.</b>	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>150X</b> IMMEDIATE CAUSE (a) <b>cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic esophageal cancer</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>Dec 27</b> , 19 <b>76</b> , to <b>Jan 10</b> , 19 <b>77</b> , that (1) (we) lost saw the deceased alive on <b>Jan 10</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>D. J. Haidak</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/11/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DJ HAIDAK MD</b>		22e. ADDRESS <b>6525 Belcrest Rd Hyattsville</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/14/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HARMONY MEMORIAL CEM.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND, PR. GEO. CO., MD.</b>		24 FUNERAL DIRECTOR <b>Laneys Home</b>			
25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>			





STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02144

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Debonna Veronica Huff</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 8 1977</b>			2b. HOUR <b>8:01</b> AM					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-29-93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GERMANY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>GERMANY</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.					
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD.</b>			13b. COUNTY <b>PRINCE GEO</b>		13c. CITY OR TOWN <b>BELTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11206 STEPHEN LANE</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>KONRAD DIEMER</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BARBARA WALZ</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO <b>218-38-6208</b>	
17. INFORMANT ADDRESS <b>JOHANNA FELDMANN SAME AS 13</b>			17. INFORMANT ADDRESS <b>DAUGHTER</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF b. <b>Paroxysmal Tachycardia</b> DUE TO, OR AS A CONSEQUENCE OF c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 hours</b> <b>10 hours</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>1970</b> to <b>Jan. 8 1977</b> , that (I) (we) lost saw the deceased alive on <b>1/8/77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <b>Alan R. Gair MD</b>			DEGREE			22c. DATE SIGNED <b>1/9/77</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN R. GAIR MD</b>			22e. ADDRESS <b>11700 Old Columbia Pike Silver Spring, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>			23b. DATE <b>1/11/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ALEXANDRIA VIRGINIA</b>				
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>			ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCready</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02145

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Thomas Marion Hunter</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-3-77</b>		2b. HOUR <b>12:32 AM</b>		
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5-27-07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>American</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PEPCO</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>811 Philadelphia Avenue</b> Zip-20910			
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Hunter</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Edwards</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>none</b>		17. INFORMANT ADDRESS <b>5404 Waycross Dr.,</b> <b>Mrs. Julia Moring-sister Alex., Va. 22310</b>			

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute gastric hemorrhage "terminal"</b> 1541 DUE TO, OR AS A CONSEQUENCE OF (b) <b>advanced ca of rectum</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

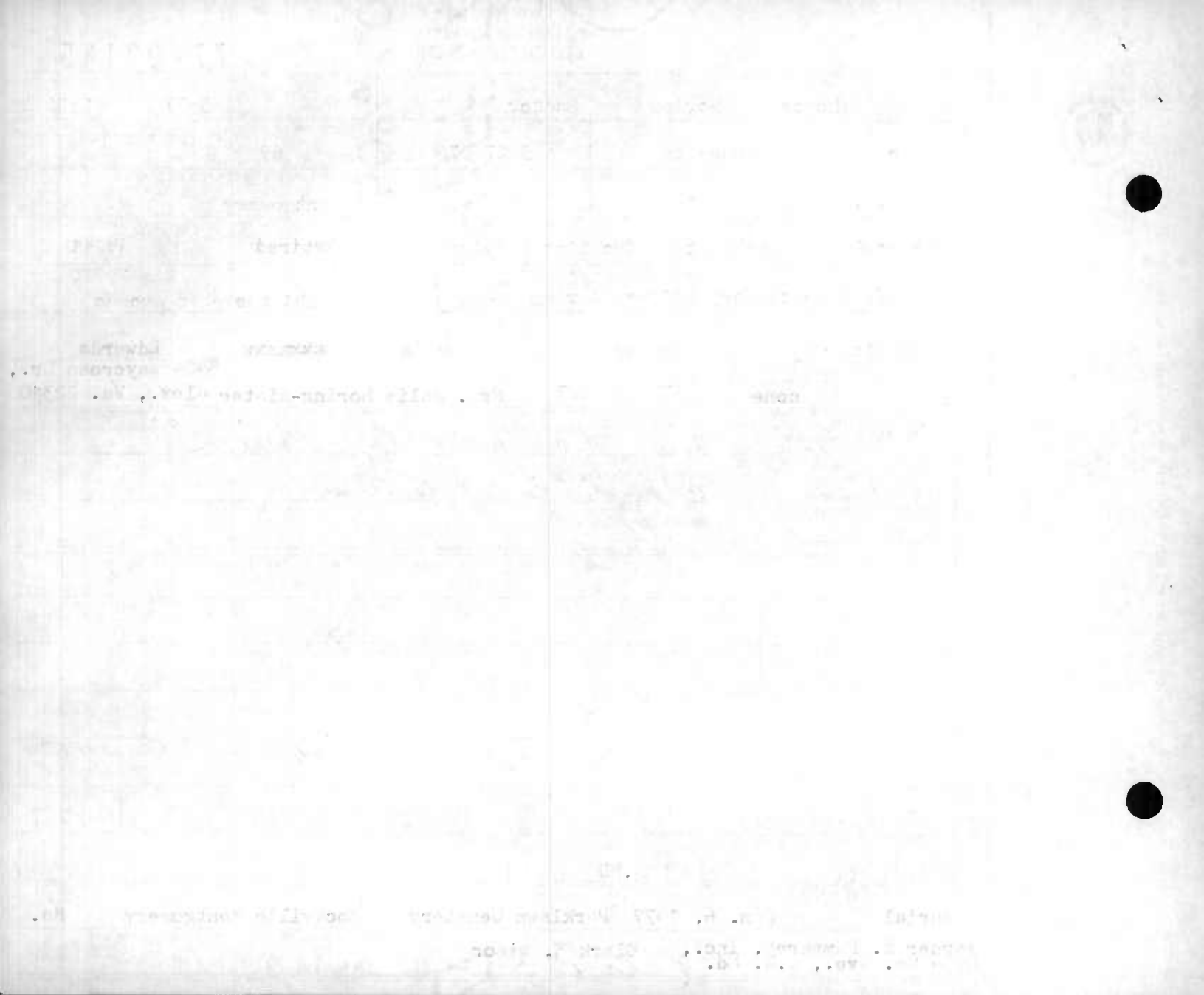
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/12</b> , 19 <b>76</b> , to <b>1/3</b> , 19 <b>77</b> , that (I/we) most saw the deceased alive on <b>1/2</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Arthur J. Willets</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/4/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur J. Willets, MD</b>				22e. ADDRESS <b>1111 Spring St. Silver Spring, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 6, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Montgomery Md.</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.,</b> <b>8434 Ga. Ave., S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>Jan 10 1977</b>			
25b. REGISTRAR'S SIGNATURE <b>Clark E. Wason</b>				25c. REGISTRAR'S SIGNATURE <b>Barney McCreedy</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. If the death is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHFOR  
STATE  
REGISTRAR

REG. NO. 77-02146

1. DECEASED NAME FIRST MIDDLE LAST <i>Eugenie Kennelly Hyatt</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1-24-77</i>		2b. HOUR <i>1:00 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11-09-03</i>		
6. AGE (IN YEARS LAST BIRTHDAY) <i>73</i> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore Md</i>		7b. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.				
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>School Teacher</i>		
12b. KIND OF BUSINESS OR INDUSTRY <i>Mont. School</i>		13a. STREET ADDRESS <i>102 Lucas Lane</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>DANIEL KENNELLY</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katherine Golden</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		
16b. SOCIAL SECURITY NO. <i>219-36-7823</i>		17. INFORMANT <i>Lloyd W Hyatt</i>		ADDRESS <i>Home 2013</i>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Perforated Aorta</i> 5193 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic Obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 yr</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 23</i> 19 <i>77</i> , to <i>Jan 27</i> 19 <i>77</i> , that (I) <del>have</del> lost saw the deceased alive on <i>Jan 23</i> 19 <i>77</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>have</del> (did not) view the body after death.						
22b. SIGNATURE <i>William H. Killay</i>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1-24-77</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William H. Killay</i>		22e. ADDRESS <i>8218 Wisconsin Ave. Bethesda, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>1/28/77</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery, Frederick, Maryland</i>		
23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bethesda, Maryland</i>		24. FUNERAL DIRECTOR NAME <i>ROBERT A. PUMPHREY FUNERAL HOMES, P.A.; BETHESDA, MARYLAND</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 31 1977</i>		
25b. REGISTRAR'S SIGNATURE <i>Anthony McCready</i>						

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

ADORE

1980 DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 77-02147								
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
JAMES L. IVERSON			1 6 77			9 0 7			M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
MALE		WHITE		JUNE 21 1921		55		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MAINE		U.S.A.				MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK		WASHINGTON ADVENTIST HOSP				TAXICAB DRIVER		SAME		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?			13d. STREET ADDRESS	
MD.			MONT			TAKOMA PARK			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
MARTIN			NAOMI							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
YES			W.W. II			WAYNE IVERSON, 13810 CASTLE BLVD. S.S.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lung Cancer with metastasis</u> 4 months plus										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Obstructive Lung Disease</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
9/15/76			Left Prescavalent Node biopsy			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED			21e. PLACE OF INJURY			21f. LOCATION				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 6</u> 19 <u>77</u> to <u>Jan 6</u> 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>Jan 6</u> 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			22c. DATE SIGNED				
Alan R. Gair MD						1/6/77				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
ALAN R. Gair MD			11700 Old Columbia Pike Silver Spring, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial			Jan. 10. 1977		Dwyer Washington		Daphn. COUNTY STATE			
24. FUNERAL DIRECTOR NAME			25a. DATE RECEIVED BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Takoma F.H. Inc			JAN 11 1977			P. B. McCreedy				

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02148

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM A JACKSON JR.			2a. DATE OF DEATH MONTH DAY YEAR 1 5 77		2b. HOUR 9 <sup>25</sup> AM
3. SEX Male	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 3 25 27		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Randolph Hills Nurs Home		9b. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY Md MONT		13c. CITY OR TOWN Silver Spring		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mason	
14. FATHER'S NAME FIRST MIDDLE LAST William A Jackson Sr		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Ellison		12b. KIND OF BUSINESS OR INDUSTRY Construction	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WW II		16b. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT ADDRESS (Wife) MRS ROXANNA JACKSON, Same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) SQUAMOUS CARCINOMA - Esophagus DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			

19a. DATE OF OPERATION 11-1-76		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA Esophagus - GASTROSTOMY		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-26, 1976, to 1-5-1977, that (I) (we) lost saw the deceased alive on 1-3-1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Roland Imperial M.D.		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11: PM 1-5-77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROLAND IMPERIAL M.D.		22e. ADDRESS 4977 BATTERY LANE Bethesda Md					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-8-77		23c. NAME OF CEMETERY OR CREMATORY Good Hope Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md	
24. FUNERAL DIRECTOR NAME George R. Snowden		24b. ADDRESS 346 N. WASH. ST. Rockville, Md.		25a. DATE REC'D BY REGISTRAR JAN 10 1977		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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JUL 11 1963  
U.S. DEPT. OF JUSTICE

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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02149

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Yvette Dawn JANAS			2a. DATE OF DEATH MONTH DAY YEAR January 17 1977		2b. HOUR 244 A M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan. 16 1977		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 13 56	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia			13b. COUNTY Pr. William		13c. CITY OR TOWN Stafford
14. FATHER'S NAME FIRST MIDDLE LAST Donald P. Janas, Jr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sheila Mae Smith		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Donald P. Janas See item 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Respiratory Distress</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Prematurity and Sepsis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 16</u> , 19 <u>77</u> , to <u>Jan. 17</u> , 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>Jan. 17</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>James W. Thorp</u> 22b. PHYSICIAN'S NAME (TYPE OR PRINT) James W. Thorp				22c. DATE SIGNED Jan. 18, 1977	
22e. ADDRESS National Naval Medical Center, Bethesda, Md.				22c. DATE SIGNED Jan. 18, 1977	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/24/77		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.		23e. DATE RECEIVED BY REGISTRAR JAN 26 1977		23f. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	

24. FUNERAL DIRECTOR NAME Robt. A. Pumphrey Funeral Home, Bethesda, Md.		25a. DATE RECEIVED BY REGISTRAR JAN 26 1977		25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>	
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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02150

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>George Allen Jeffries</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1/7/77</i>		2b. HOUR <i>2:40 P.M.</i>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <i>JULY 29, 1900</i>		6 AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MACHINIST</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVT</b>
13a. STATE <b>MD.</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ELIZA WILLIAMS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>579-38-5343</b>		17. INFORMANT ADDRESS <b>KATHERINE J. KNICELY SAME AS 13 SISTER</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Vascular accident</i> (c) <i>Stomach dermoids &amp; stone whose leg 8 months</i> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>B. I. hemorrhage. Fibrilate change lungs. SBBB</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>sudden</i> <i>8 months</i>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTO PSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Mar 5</i> , 19 <i>1968</i> , to <i>Jan 7</i> , 19 <i>77</i> , that (I) (we) last saw the deceased alive on <i>Jan 7</i> , 19 <i>77</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Philip E. Jones</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>1/7/77</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Philip E. Jones</i>		22e. ADDRESS <i>9601 Callesville Rd Silver Spring Md 20901</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <i>1/11/77</i>		23c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>		
23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON, D. C.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>FRANCIS J. COLLINS</b> <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		25a. DATE REC'D. BY REGISTRAR <i>JAN 17 1977</i>		
				25b. REGISTRAR'S SIGNATURE <i>Henry McCready</i>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



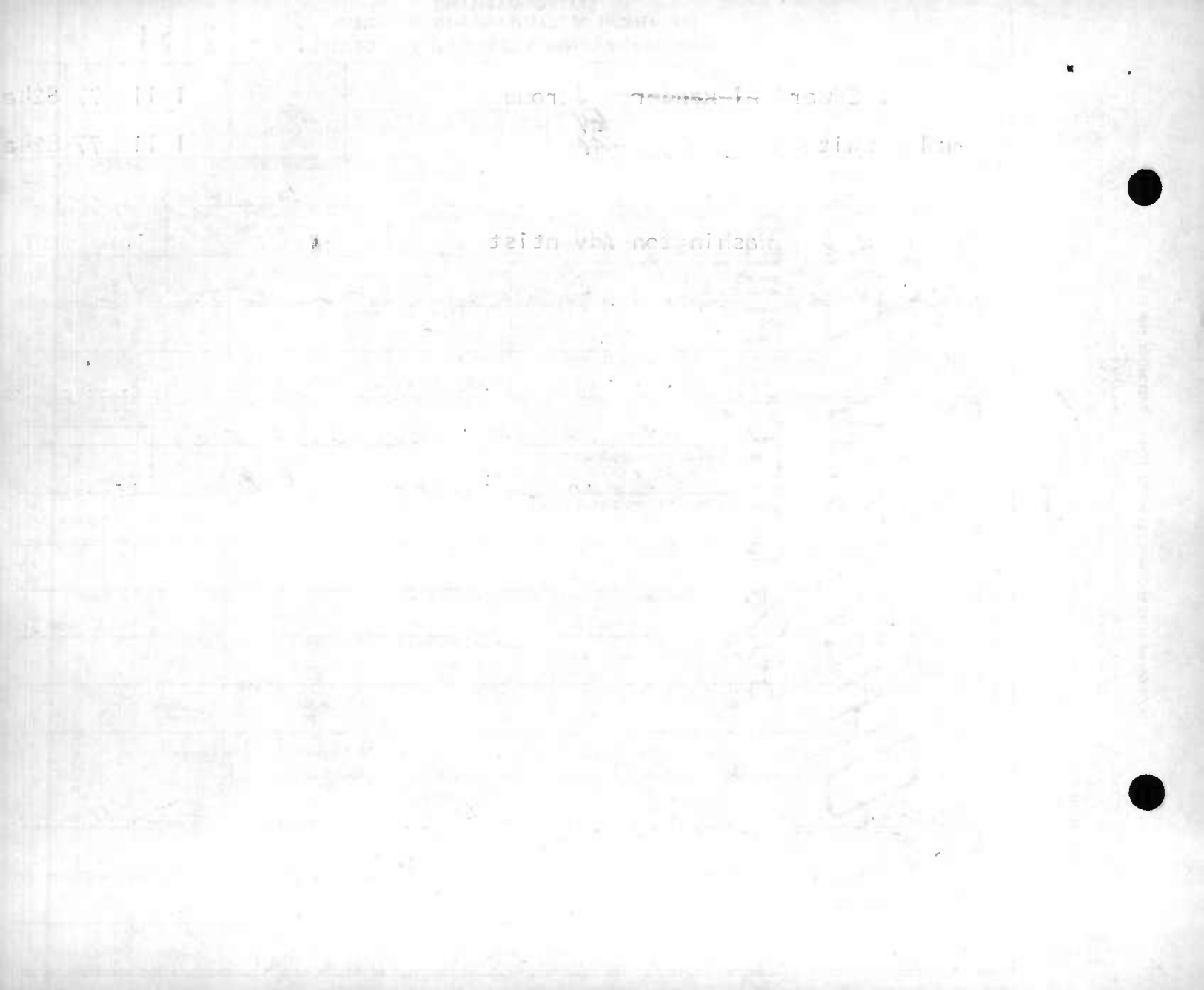


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VRA15 ME (5))  
30M 7/73

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 77-02151									
1. FOR STATE REGISTRAR										20. DATE KNOWN OF DEATH		21. HOUR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST DR. Edward Alexander Jerome										DATE ESTIMATED		MONTH DAY YEAR		HOUR					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		22. DATE PRONOUNCED DEAD		23. HOUR					
male		white		3 28 12 54		S.		MONTHS DAYS HOURS MIN		MONTH DAY YEAR		1 11 19 77		824					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY, MD.							
10. CITY OR TOWN OF DEATH Tak Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist				12a. USUAL OCCUPATION (TYPE OF WORK) RESEARCHER				12b. KIND OF BUSINESS OR INDUSTRY PSYCHOLOGY							
13a. STATE Md				13b. COUNTY Prince Georges				13c. CITY OR TOWN Hyattsville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS Fitz 15th Ave			
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD JEROME				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSE UNKNOWN				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 498-28-6556				17. INFORMANT ADDRESS 10024 PARK WEST CHAPELS 115W. 79th ST. N.Y., N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 428X IMMEDIATE CAUSE (a) Acute Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs.										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None									
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE J. B. Pagan						TITLE (SPECIFY) M.D. Rep.						DATE SIGNED Jan 11, 1977							
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL-BURIAL				23b. DATE 1-11-77				23c. NAME OF CEMETERY OR CREMATORY MOUNT PLEASANT				23d. LOCATION CITY OR TOWN COUNTY STATE NEW YORK, NEW YORK							
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS.						ADDRESS 6010 REISTERSTOWN ROAD						25a. DATE REC'D. BY REGISTRAR JAN 17 1977		25b. REGISTRAR'S SIGNATURE Patrick McCready					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP  
DHMH - 16 60M 7/73  
(VR 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			77-02152				REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
FIRST MIDDLE LAST Nok Lun Jew			MONTH DAY YEAR 1-26-77			6 <sup>00</sup> P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Female		Oriental		MONTH DAY YEAR 6 6 03		73 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
China		China				Montgomery County, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		14661 Stonewall Drive			Housewife		Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
--		N --		Wash., D.C.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		216 2nd Street, S.E.	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Hok Founne Woon					FIRST MIDDLE LAST Lei See Lee				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No			--		579-68-9118 Thick Gim Jew-husband Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
1538 IMMEDIATE CAUSE (a). Carcinoma of the Colon (11-76)									
DUE TO, OR AS A CONSEQUENCE OF									
(b)									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
N/A									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
N/A					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from December 12, 1976, to 1/26, 1977, that (I) (we) lost saw the deceased alive on 1/17/77, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
Peter E. Petrucci, M.D.					M.D.			1/26/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Peter E. Petrucci, M.D.					3800 Reservoir Rd., N.W., Washington, D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1-31-1977		Fort Lincoln Cem.		Brentwood, Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Lee Fun. Home 300-4th St., NE, Wash., D.C.				JAN 31 1977		[Signature]			



M

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02153

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) First: <u>Estelle</u> Middle: <u>C</u> Last: <u>Johns</u>			2a. DATE OF DEATH MONTH: <u>1</u> DAY: <u>18</u> YEAR: <u>77</u>			2b. HOUR <u>2:16</u> A M					
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH: <u>4</u> DAY: <u>12</u> YEAR: <u>85</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>91</u> YRS.		IF UNDER 1 YEAR MONTHS: _____ DAYS: _____		IF UNDER 24 HRS HOURS: _____ MIN: _____	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Berryville, Va</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.					
10. CITY OR TOWN OF DEATH <u>Kensington, Md</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Kensington Gardens Nursing Home</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: <u>Md.</u> 13b. COUNTY: <u>Montgomery</u> 13c. CITY OR TOWN: <u>Kensington</u>						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <u>11332 Mitscher St.</u>			
14. FATHER'S NAME First: <u>Jaquelin</u> Middle: <u>Smith</u> Last: <u>Powers</u>						15. MOTHER'S MAIDEN NAME First: <u>Estelle</u> Middle: <u>Castleman</u> Last: _____					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT ADDRESS: <u>William Johns Kensington, Md.</u>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <u>4409</u> IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last: <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 24, 1976</u> to <u>Jan 18</u> , 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>Jan 17</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE <u>A.W. Smith M.D.</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/18/77</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A.W. SMITH</u>						22e. ADDRESS <u>13018 GEORGETTA AVE WHEATON, MD. 20906</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				23b. DATE <u>1/19/77</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Berryville, Clarke Va.</u>			
24. FUNERAL DIRECTOR NAME: <u>Enders Funeral Home, Berryville, Va.</u> ADDRESS: _____						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Litkey McCready</u>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02154

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TARYN ANN KALINOWSKI		2a. DATE OF DEATH MONTH DAY YEAR JANUARY 15, 1977		2b. HOUR 0039A M	
3 SEX FEMALE		4 RACE CAUCASIAN		5 DATE OF BIRTH MONTH DAY YEAR DECEMBER 11, 76		6. AGE (IN YEARS LAST BIRTHDAY) NA YRS. MONTHS DAYS 01 04	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ICELAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NA		12b. KIND OF BUSINESS OR INDUSTRY NA	
13a. STATE MAINE		13b. COUNTY YORK		13c. CITY OR TOWN OGUNQUIT		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST ROBERT ZYGMUNT KALINOWSKI		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SHARON RAE DAVIS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO NA			
16b. SOCIAL SECURITY NO. NA		17. INFORMANT ADDRESS ROBERT Z. KALINOWSKI 33 SHORE DR ME 03907					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: 7469 IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>EXTREME HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGENITAL HEART DISEASE</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE							
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED NA		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <u>07 JANUARY</u> , 19 <u>77</u> , to <u>15 JANUARY</u> , 19 <u>77</u> , that (we) lost saw the deceased alive on <u>15 JANUARY</u> , 19 <u>77</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (not) view the body after death							
22b. SIGNATURE <i>T. R. Montgomery, M.D.</i>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 15 JAN 77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T.R. Montgomery, M.D.		22e. ADDRESS NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20014					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Spring '77		23c. NAME OF CEMETERY OR CREMATORY Ocean View Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wells, Maine	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland				25. DATE REC'D. BY REGISTRAR JAN 19 1977			





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02155

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

FRANCES

V.

KASSNER

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

1 27 77

2 P.M.

3 SEX

FEMALE

4 RACE

CAUC.

5. DATE OF BIRTH

12/ 12/ 1939<sup>RR</sup>

6 AGE (IN YEARS LAST BIRTHDAY)

37

IF UNDER 1 YEAR

IF UNDER 24 HRS.

MONTHS

DAYS

HOURS

MIN.

7a BIRTHPLACE (STATE OR FOREIGN  
COUNTRY)

MARYLAND

7b CITIZEN OF WHAT COUNTRY?

U.S.A.

8 MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9 BALTIMORE CITY OR COUNTY OF DEATH

MONTGOMERY

MD.

10 CITY OR TOWN OF DEATH

BETHESDA

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION  
(IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)

SUBURBAN HOSPITAL

12a USUAL OCCUPATION  
(NATURE OF WORK OR BEST OF WORK)

TEACHER'S ASS'T

12b. KIND OF BUSINESS OR  
INDUSTRY

EDUCATION

13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a STATE

MARYLAND

13b COUNTY

MONTGOMERY

13c CITY OR TOWN

ROCKVILLE

13d INSIDE CITY LIMITS?

YES ☒ NO ☐

13e STREET ADDRESS

718 CRABB AVENUE

14 FATHER'S NAME

OBIE T. TYLER

MIDDLE

LAST

15 MOTHER'S MAIDEN NAME

GRACIE

MIDDLE

FORD

LAST

16a WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO OR UNKNOWN)

NO

16b SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

UNKNOWN

17 INFORMANT

ADDRESS

MARVIN W. KASSNER (SAME AS 13e)

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

4319

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Brain Death  
Intra cranial hemorrhage  
Vascular RuptureAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

48 hrs

#48 hr

"

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a AUTOPSY?

20b IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?21a ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f LOCATION

CITY OR TOWN

COUNTY

STATE

22a I certify that (I) (was hospital) attended the deceased from 1-25-77 19 to 1-27-77 19 77, that (I) (lost  
saw the deceased alive on 1-27-77 19, and that in (my) (her) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

1-27-77

22d PHYSICIAN'S NAME (TYPE OR PRINT)

Jonathan M. Williams

22e ADDRESS

808 Pershing Dr Silver Spring

23a BURIAL, CREMATION, REMOVAL  
(SPECIFY)

BURIAL

23b. DATE

1/31/77

23c. NAME OF CEMETERY OR CREMATORY

PARKLAWN MEMORIAL PARK

23d. LOCATION  
CITY OR TOWN

ROCKVILLE

COUNTY

MARYLAND

STATE

24 FUNERAL DIRECTOR

TYSON WHEELER FUNERAL HOME, ROCKVILLE, MARYLAND

25a DATE RECD. BY REGISTRAR

FEB 3 1977

25b REGISTRAR'S SIGNATURE

Marking McCreedy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

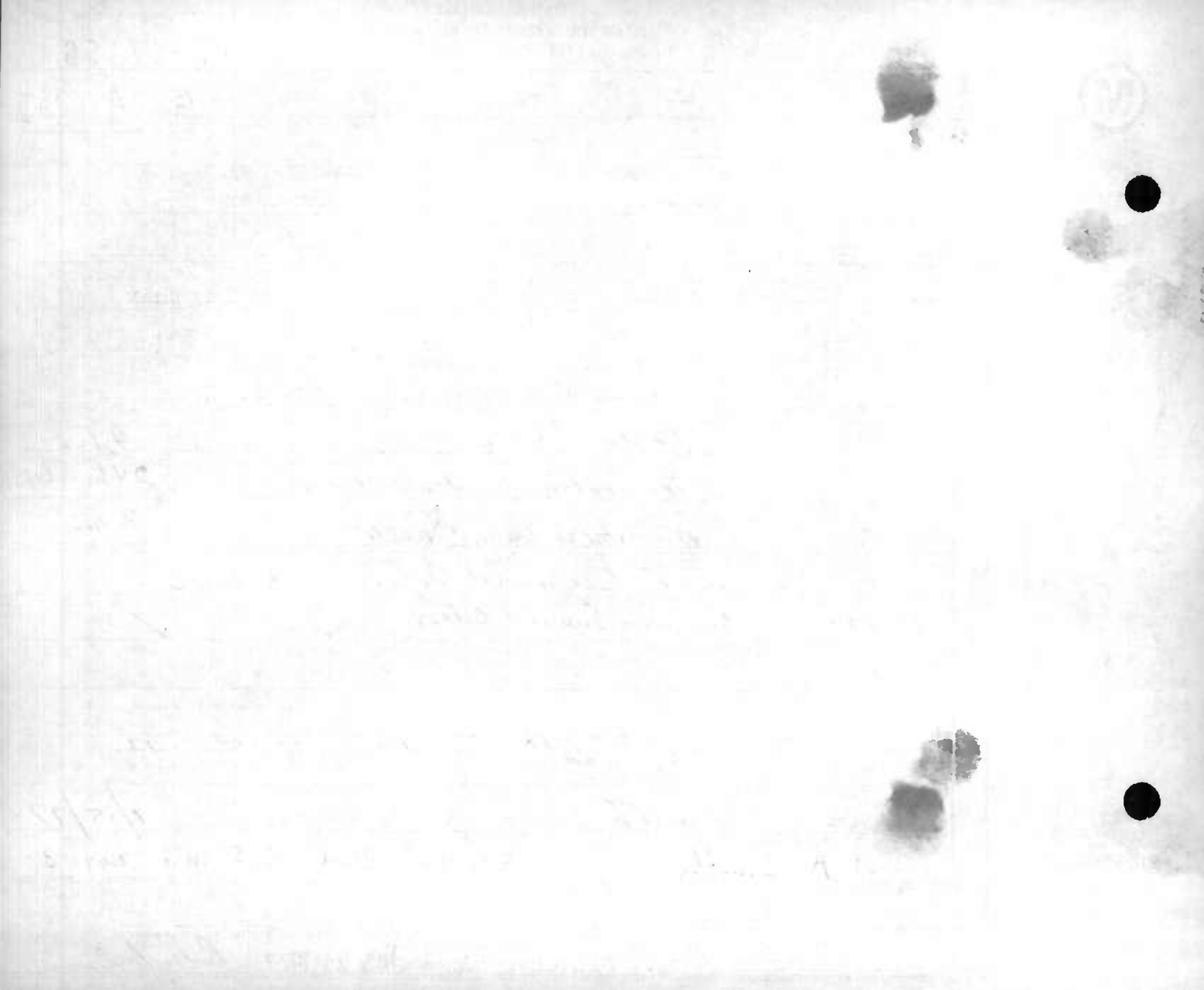
77-02156

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ernest — Kaszas</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>1-15-77</i>			2b. HOUR <i>10<sup>30</sup> A.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>2 22 18</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>58</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Hungary</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Photo lab technician-Smithsonian Institute</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>8500 New Hampshire Ave.</i>	
13a. STATE <i>Md.</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Sil. Spring</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ernest Kaszas</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Margaret (unknown)</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>W. W. II 069-12-0246</i>		17. INFORMANT ADDRESS <i>Mary Ann Kaszas, see Item #13</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Septic Shock</i> 1621 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Perforated Duodenal Ulcer</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Metastatic Lung Cancer</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i> <i>24 hrs or less</i> <i>3 mo.</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>P.D. Gangrene Sigmoid Colon 3 days</i>							
19a. DATE OF OPERATION <i>1/11/77</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Gangrene Sigmoid Colon</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <i>1-10</i> , 19 <i>77</i> , to <i>1-15</i> , 19 <i>77</i> , that (I) (we) last saw the deceased alive on <i>1-15</i> , 19 <i>77</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
27a. SIGNATURE <i>Robert A. Smith</i>				DEGREE <i>Attending Physician</i>		27b. DATE SIGNED <i>1/15/77</i>	
27c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Robert A. Smith</i>				27d. ADDRESS <i>831 Univ. Blvd. S.S. Md 20903</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b. DATE <i>1/18/77</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Farrell, Pennsylvania</i>	
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi Funeral Home, Inc.</i>				25. DATE REC'D. BY REGISTRAR <i>JAN 21 1977</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McCready</i>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 should be detached for use as the burial-transit permit. Then please remove remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove remaining pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

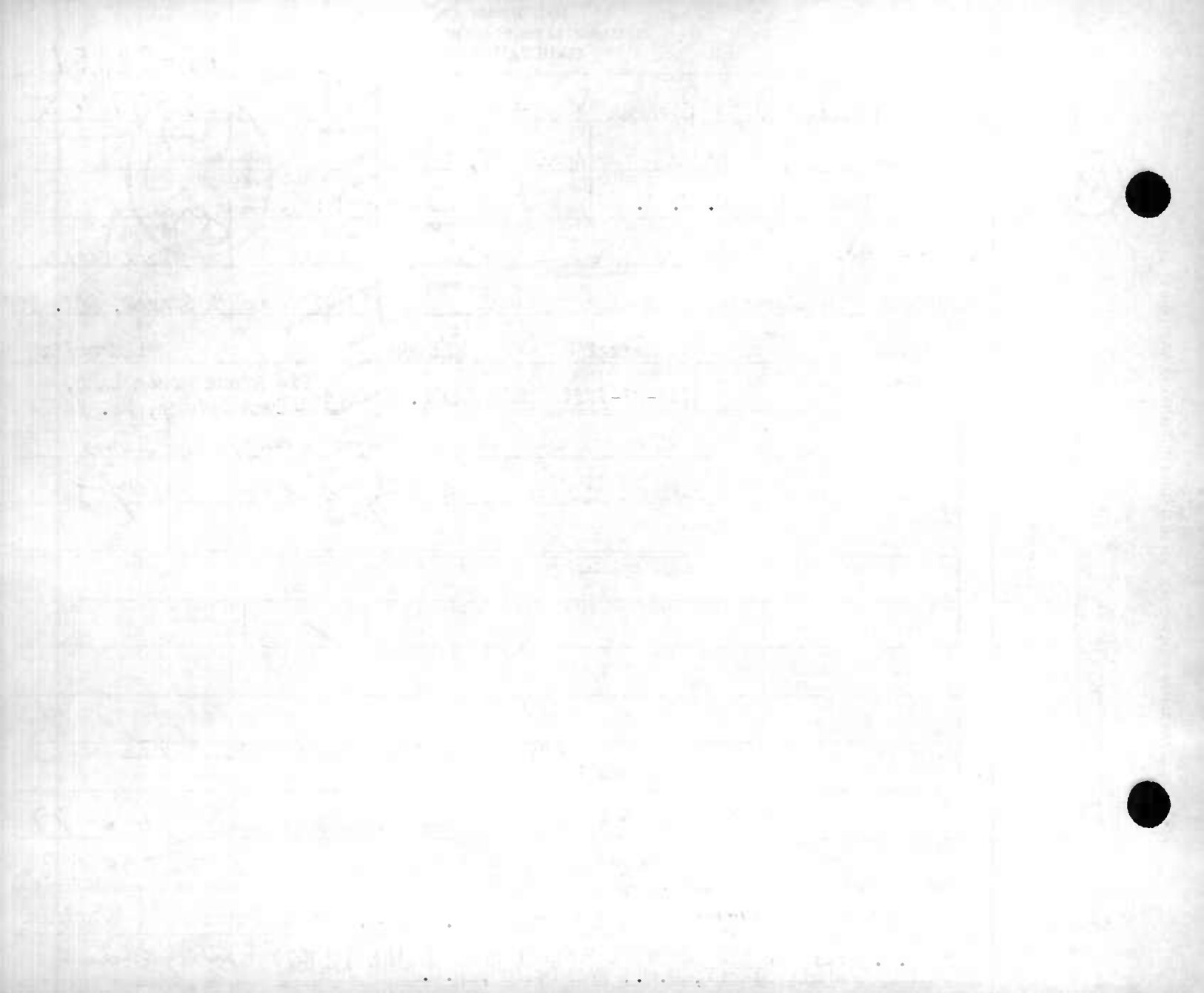


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 77-02157			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 1-6-77			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Harold Berman Katzel				2b. HOUR 8A <sup>2</sup> M			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 13, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broker		12b KIND OF BUSINESS OR INDUSTRY Real Estate	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13e STREET ADDRESS 10601 Weymouth Street, Apt. 204	
14 FATHER'S NAME FIRST MIDDLE LAST Louis Katzel				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Ledkowitz			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 108-01-1821		17. INFORMANT ADDRESS William L. Katzel 524 Stone House Lane, Silver Spring, Md. 20904			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary occlusion - congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) severe coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 4, 1977, to Jan 6, 1977, that (I) (we) lost saw the deceased alive on 1-5-1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Stephen W. DeJager, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1-6-77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN W. DEJAGER, MD				22e. ADDRESS 6719 WILSON LA, BETHESDA, MD 20834			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/7/77		23c. NAME OF CEMETERY OR CREMATORY King David Mem. Garden		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia	
24 FUNERAL DIRECTOR NAME D.M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.				25a. DATE REC'D. BY REGISTRAR JAN 12 1977		25b. REGISTRAR'S SIGNATURE Patrick McCreedy	



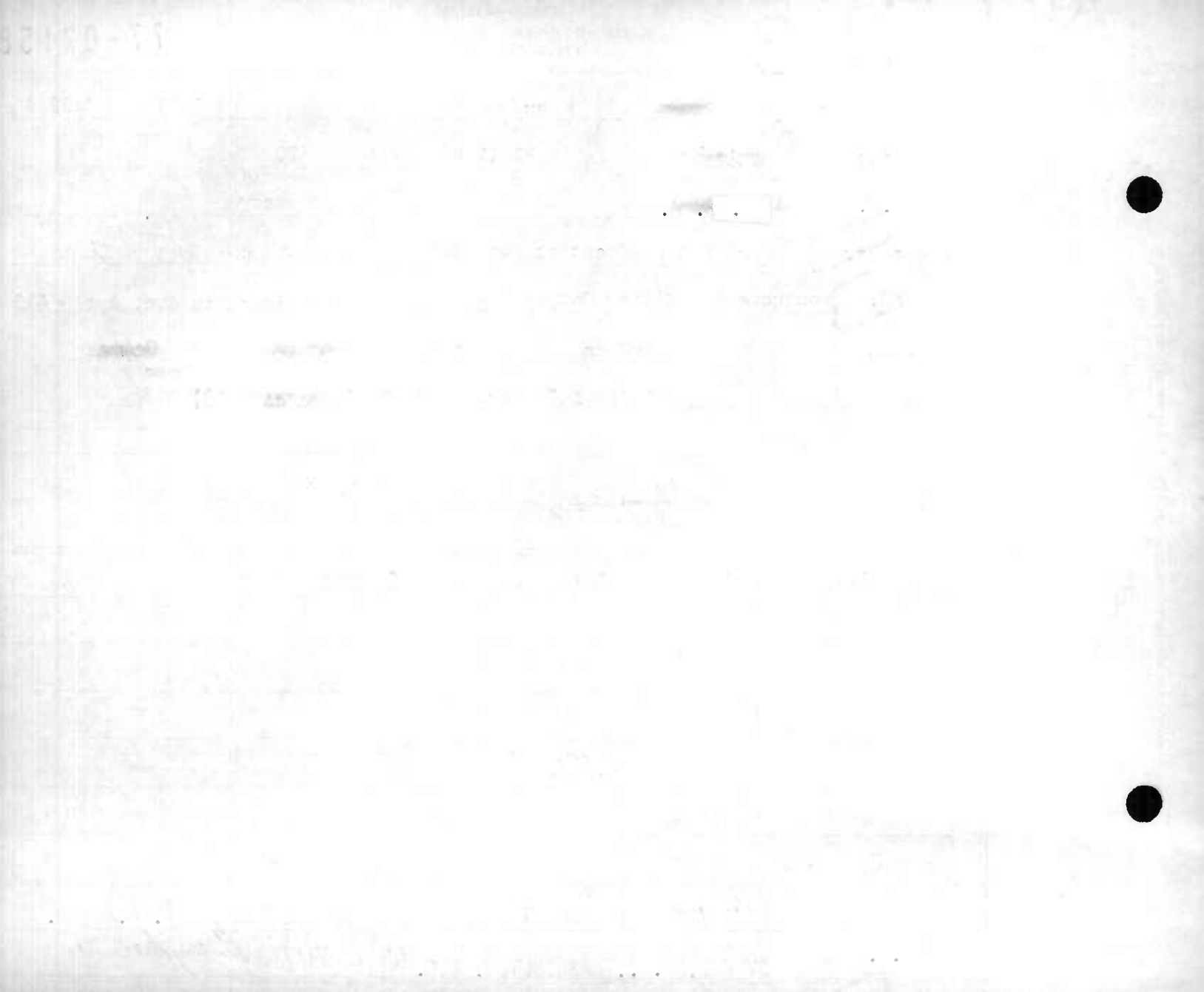
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02158

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Dave Kaufman</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-7-77</b>			2b. HOUR <b>1:55 A.M.</b>				
3 SEX <b>Male</b>		4. RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>12-12-06</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Restaurant Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2301 Glenallan Ave. Apt # 415</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Kaufman</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lena Gelman</b>			ADDRESS Phone				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-52-1507</b>		17 INFORMANT <b>Sarah Kaufman - (Same as # 13) - 1151</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary Edema</b> <b>4123</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic obstructive pulmonary disease</b> (c) <b>with congestive failure</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b> <b>Chronic obstructive pulmonary disease</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>June</b> , 19 <b>76</b> , to <b>Jan</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>Jan 6</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Boris Rabin</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-7-77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BORIS RABKIN</b>						22e. ADDRESS <b>1019 Unit 200 East Silver Spring Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/10/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT LEBANON</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>HYATTSVILLE, P. G. MD.</b>		
24. FUNERAL DIRECTOR NAME <b>D.M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>		
232 CARROLL STREET, N.W., WASHINGTON, D.C.										





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02159

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Rosa Dora Stone Keatley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 27, 1977</b>			2b. HOUR <b>1:20PM</b>				
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 22 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Cuba</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Asst. Admin. (Ret.)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>O.A.S.</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md. 20906</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3358 Chiswick Ct.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John H Stone</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Serrate</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-58-7749</b>		17. INFORMANT <b>Husband</b> ADDRESS <b>G. Harold Keatley. Same as item 13.</b>					

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4379</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic cerebrovascular disease unknown</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic obstructive lung disease with acute pulmonary insufficiency</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 1977, to _____, 1977, that (I) (we) last saw the deceased alive on _____, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did) (did not) saw the body after death.					
22b. SIGNATURE <b>John G. Lodmell</b> DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>1/27/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John G. Lodmell, M.D.</b>				22e. ADDRESS <b>18111 Prince Philip Drive, Olney MD 20832</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/2/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Ridge Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Centre County Pa. Fleming (Unionville Borough)</b>	
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS, INC.</b> <b>5130 WISCONSIN AVENUE</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1977</b>			
				25b. REGISTRAR'S SIGNATURE <b>Henry McCready</b>			

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January 24, 1917

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 77-02160							
1. DECEASED NAME (TYPE OR PRINT)		FIRST PAUL		MIDDLE J.		LAST KIRKPATRICK		2a. DATE OF DEATH MONTH DAY YEAR	
Paul		Jerome		Kirkpatrick		1-9-77		2b. HOUR 11 <sup>12</sup> M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		white		8-23-98		78		YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BETHESDA		SUBURBAN HOSPITAL		Maint. Engineer		Office Bldg.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Worcester		Ocean City		YES <input type="checkbox"/> NO <input type="checkbox"/>		300 N. 4th St	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
James		Kirkpatrick		Elizabeth		Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		215-10-4584		Roland H. Berger, Jr. 1304 Fallsmead Way Rockville, Md 20854					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 600X Uremia								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								DUE TO, OR AS A CONSEQUENCE OF (b) Benign Prostatic Hypertrophy Uncertain	
								DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic Lymphocytic Leukemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from 4/6/77 to 1/9/77, that (we) last saw the deceased alive on 1/9/77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		22c. DATES SIGNED					
James W. Egan MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/9/77					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JAMES W. EGAN		5413 Cedar Lane		Baltimore, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1/11/1977		New Cathedral Cemetery		Baltimore, Md.			
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
JOSEPH GAWLER'S SONS, INC.		5130 WISCONSIN AVENUE, N.		JAN 13 1977		Henry McCreedy			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Margaret Louise Knaus						2a. DATE OF DEATH MONTH DAY YEAR January 5, 1977		2b. HOUR 3:50 P	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 31, 1919		6. AGE (IN YEARS LAST BIRTHDAY) YRS 57		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Conn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Conn.		13b. COUNTY Hartford		13c. CITY OR TOWN Newington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 50 - 5th St.	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Duld				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Brineger					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 042-14-5956		17. INFORMANT ADDRESS William H. Knaus Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diffuse mixed lymphoma 2022 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 15 December 1976 to 05 January 1977 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 05 January 1977, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.									
22b. SIGNATURE Joseph E. Mason, Jr. MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 1/6/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph E. Mason, Jr.				22e. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 8, 1977		23c. NAME OF CEMETERY OR CREMATORY Center Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Newington, Conn.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A.				25a. DATE REC'D. BY REGISTRAR JAN 17 1977		25b. REGISTRAR'S SIGNATURE Henry McCurdy			

121-02161



CONFIDENTIAL  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
JAN 21 1971  
TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [Illegible]  
RE: [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02162

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY KREMENS</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>11 22 77</b>		2b. HOUR <b>10:30 PM</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>2 1 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York City</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holm Cross</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Julius Abrahams</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Cohen</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>126-24-4411</b>		17. INFORMANT ADDRESS <b>William Kremens 5 Saddlerock Court, Silver Spring, Md. 20902</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>2381 IMMEDIATE CAUSE (a) BRAIN TUMOR</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <div style="display: inline-block; vertical-align: middle; margin-left: 10px;">         } DUE TO, OR AS A CONSEQUENCE OF (b)          } DUE TO, OR AS A CONSEQUENCE OF (c)       </div>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 10 19 77</b> , to <b>JAN 22 19 77</b> , that <del>the</del> (we) lost saw the deceased alive on <b>JAN 22 19 77</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>the</del> (we) <del>did</del> (did not) view the body after death.					
22b. SIGNATURE <b>Morton A. Hschruler MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1-23-77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Morton A. Hschruler MD</b>		22e. ADDRESS <b>2131-Edgewater Parkway Silver Spring Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/24/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT ARARART CEMETERY FARMINGDALE, NEW YORK</b>	
24. FUNERAL DIRECTOR NAME <b>D.M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Hickey McBrady</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>232 CARROLL STREET, N.W., WASHINGTON, D.C.</b>					

MEDICAL CERTIFICATION

2  
X

2601

SE150-1

UNITED STATES  
DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
REG. NO. 77-02163									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY JANE KUGEL					2a. DATE OF DEATH MONTH DAY YEAR JANUARY 27, 1977			2b. HOUR 3:22A M	
3 SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR 11/30/15		6 AGE (IN YEARS LAST BIRTHDAY) 61		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Mexico		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8401 Peck Place				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Volunteer Social Worker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8401 Peck Place	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Hamilton Meeker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Ella Corn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 374-28-2953		17. INFORMANT ADDRESS Thomas L. Kugel, same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Syptotic Failure</u> 1538 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coccolonia of the Colon.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 wks. 30 mos.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>aug</u> , 19 <u>74</u> , to <u>1/27</u> , 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>1/17</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John J. Lynch</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/27/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN J LYNCH				22e. ADDRESS 106 IRVING ST NW					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/1/77		23c. NAME OF CEMETERY OR CREMATORY Potomac Meth. Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Potomac, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25a. DATE REC'D. BY REGISTRAR FEB 3 1977		25b. REGISTRAR'S SIGNATURE <u>Henry McCreedy</u>			
7557 Wisconsin Ave., Bethesda, Md.									

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1 - FOR  
STATE  
REGISTRAR

REG. NO. 77-02164

1 DECEASED NAME (TYPE OR PRINT) <b>BALLE FRIED LANDAU</b>		2a DATE OF DEATH MONTH DAY YEAR <b>JAN 2 77</b>		2b HOUR <b>7:45 AM</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>August 24, 1889</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>		10 CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens Nursing Home</b>	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Saleslady</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		13a STREET ADDRESS <b>1026 10th Street</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Adolph Fried</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Unknown</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
16b SOCIAL SECURITY NO. <b>578-26-6127</b>		17 INFORMANT <b>Mrs. Shirley Phillips</b>		ADDRESS <b>Same as 13</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4339 Terminal Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>---</b>		21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>---</b>	
21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>---</b>		22a I certify that (I) (this hospital) attended the deceased from <b>9/15/76</b> , 19____, to <b>1/2/77</b> , 19____, that (I) (we) last saw the deceased alive on <b>12/10/76</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b SIGNATURE <b>[Signature]</b> MD	
22c DATE SIGNED <b>1/2/77</b>		22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>OSOTH LEKADOL MD</b>		22e ADDRESS <b>8218 Wisconsin Ave, Beltsville, Md</b>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>1/3/1977</b>		23c NAME OF CEMETERY OR CREMATORY <b>Judean Memorial Gardens</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>Olney, Maryland</b>		24 FUNERAL DIRECTOR NAME <b>Donald M. Stein</b>		25 DATE RECD BY REGISTRAR <b>JAN 5 1977</b>	
26 REGISTRAR'S SIGNATURE <b>[Signature]</b>		27 REGISTRAR'S NAME <b>McCreedy</b>		28 REGISTRAR'S ADDRESS <b>232 Carroll Street, N. W. Washington, D. C.</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

2/6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02165  
REG. NO.

1- FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		1:15 A.M.	
FIRST MIDDLE LAST		January 2, 1977			
Elizabeth Roberts Laubscher					
3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Caucasian	MONTH DAY YEAR	82	IF UNDER 24 HRS.	
				MONTHS	DAYS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Kansas	U.S.A.		Montgomery MD		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Rockville	R.R. Potomac Valley Nursing Home		Secretary		I.R.S.
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Md.		Montgomery	Silver Spring	YES <input type="checkbox"/> NO <input type="checkbox"/>	8505 Springvale Road
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST		FIRST MIDDLE LAST			
William O. Roberts		Margaret Lewis			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS	
No		579-58-7469		1111 23rd Rd. So. Arlington, Va.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					
PART 1. DEATH WAS CAUSED BY					
IMMEDIATE CAUSE (a) Carcinomatosis					
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the Colon					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR			
		P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-31 1976 to 1-2- 1977, that (I) (we) last saw the deceased alive on 12-31 1976, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Hubert J. Alpert, M.D.				Jan. 2, 1977	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Hubert J. Alpert, M.D.		8630 Fenton Street Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		1-3-77		Metropolitan Crematory Alexandria Va.	
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis J. Collins		JAN 6 1977		Hubert J. Alpert	
500 University Blvd. W., Silver Spring, Md.					

MEDICAL CERTIFICATION

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
6 months

2900

BP

17-02182

1936 January 2, 1937 Landeck, Colorado

1936 January 2, 1937

1936 January 2, 1937

1936 January 2, 1937

1936 January 2, 1937

1936 January 2, 1937

1936 January 2, 1937

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Continued

1936 January 2, 1937

1936 January 2, 1937

1936 January 2, 1937

1936 January 2, 1937

1936 January 2, 1937

FOR Items 18a. & 22a. DEPARTMENT OF HEALTH AND MENTAL HYGIENE																			
1- STATE REGISTRAR					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					REG. NO. 77-112186									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE KNOWN OF DEATH					2b. DATE OF ESTIMATED DEATH									
GOLDA - Mag					Lechlinder					1 6 19 77 P.M.									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD							
Female		White		May 30, 1910		66 YRS.		MONTHS		DAYS		1 6 19 77 M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Tenn.				USA								Montgomery County MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)							
Olney				Montgomery General Hospital								H. Wife							
13a. STATE										13b. COUNTY									
Maryland										Montgomery									
13c. CITY OR TOWN										13d. INSIDE CITY LIMITS?									
Silver Spring										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
13e. STREET ADDRESS										14. FATHER'S NAME									
1441 New Hampshire Ave.										George Barton									
15. MOTHER'S MAIDEN NAME										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)									
Clancy Craver										No									
16b. SOCIAL SECURITY NO.										17. INFORMANT ADDRESS									
214-03-8681-B										Mr. Clarence L. Lechlinder Same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 1 DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Myocardial infarct																			
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?									
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
					P.M. 19														
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
TITLE (SPECIFY)																			
ACTUAL SIGNATURE Bert F. Morton										M.D. Deputy Chief									
DATE SIGNED 1/8/77																			
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS									
Bert F. Morton, M.D.										111 Penn St., Baltimore, Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY									
Burial					Jan. 11, 1977					Colesville									
23d. LOCATION CITY OR TOWN COUNTY STATE					23e. DATE REC'D. BY REGISTRAR					23f. REGISTRAR'S SIGNATURE									
Colesville Mont. Md.					JAN 12 1977					Bert F. Morton									
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR									
Francis H. Barber										Laytonville, Md. 20760									



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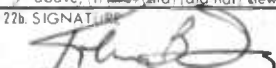

107-01



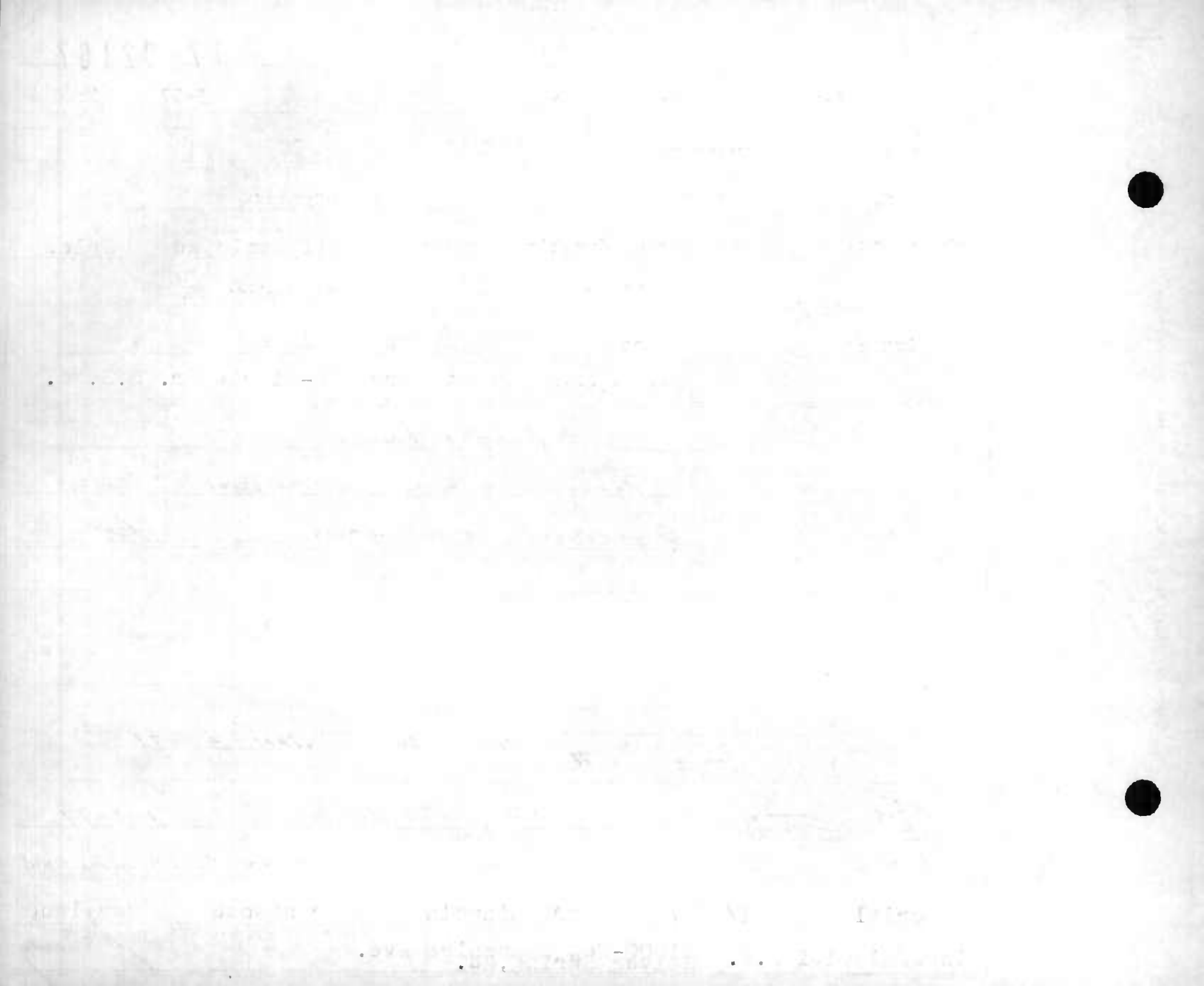
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edwin Clyde Lee</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>1-3-77</b>		2b. HOUR <b>2:00 AM</b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>6-22-06</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>American</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Employed</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sales</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>DC</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1833 Upshur NE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Kirtley Lee</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Allen</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					
16b. SOCIAL SECURITY NO <b>577-03-2243</b>		17. INFORMANT ADDRESS <b>Janet Farr 90-Eldrid Dr. S.S.Md.</b>							
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> <b>1990</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pneumonia - Grand Mal Seizures</b> 10 days DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Carcinomatosis</b> Months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>May 1976</b> to <b>JAN 3 1977</b> , that (I) (we) last saw the deceased alive on <b>JAN 2 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.									
22b. SIGNATURE 		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1-3-77</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT B. IREAY</b>		22e. ADDRESS <b>11161 New Hampshire Ave Silver Spring, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/6/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Maryland</b>		25a. DATE DEATH BY REGISTRY <b>JAN 10 1977</b> 25b. REGISTRAR'S SIGNATURE 	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi F.H.</b>		24b. ADDRESS <b>11800 New Hampshire Ave. Silver Spring, Md.</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Charles August Lehmann					2a. DATE OF DEATH 1-17-77		2b. HOUR 4:35 AM		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH 7-1-89		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? American USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERINTENDANT		12b. KIND OF BUSINESS OR INDUSTRY APT. HOUSE	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Prince Geo. 13c. CITY OR TOWN Hyattsville					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6211 Baleour Drive. W.		
14. FATHER'S NAME Johann ———— Lehmann					15. MOTHER'S MAIDEN NAME FREDERICKA ———— BRAUN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 100-07-2015		17. INFORMANT -ville, Md. ADDRESS Phone 559-9279 Dolores Pierson 6209 Baleour Dr. W. Hyatts-					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY 4123 IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis - cardiac &amp; cerebral</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Manic Depression.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 16</u> , 19 <u>77</u> to <u>Jan 17</u> , 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>Jan 16</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L. S. Fleischer</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1-17-77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. S. FLEISCHER, M.D.				22e. ADDRESS 7411 RIGGS Rd. HYATTSVILLE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 1-18-77		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRINCE GEORGE'S MD			
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME				ADDRESS 5801 CLEVELAND AVE. RIVERDALE, MD		25a. DATE REC'D. BY REGISTRAR JAN 20 1977		25b. REGISTRAR'S SIGNATURE <u>Robert McCreedy</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG NO - 02169							
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		7b. HOUR			
Mary Virginia LEMMON				Jan. 30, 1977		8:00A.			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		Aug. 4, 1881		95 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Montgomery MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital				Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Howard		Mt. Airy				Rt. 5, 16509 Frederick Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Benjamin Franklin Barnes		unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
No		216-60-7860		Clair L. Lemmon,		318 University Blvd. W. Silver Spring, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>COR PULMONALE, RIGHT HEART FAILURE</u> 5193 DUE TO, OR AS A CONSEQUENCE OF (b) <u>CHRONIC OBSTRUCTIVE LUNG DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ADENOCARCINOMA OF BREAST WITH LUNG METASTASIS</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 1/29/77 to 1/30/77, that (1) (we) lost saw the deceased alive on 1/29/77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.									
22b. SIGNATURE <u>JOEL L. GOOZH</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/30/77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
JOEL L. GOOZH		4701 RANDOLPH RD #105 ROCKVILLE, MD 20852							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Cremation		Feb. 2, 1977		Westview		Baltimore Maryland			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Olin L. Molesworth,		Damascus, Md.		FEB 2 1977		<u>[Signature]</u>			

MEDICAL CERTIFICATION

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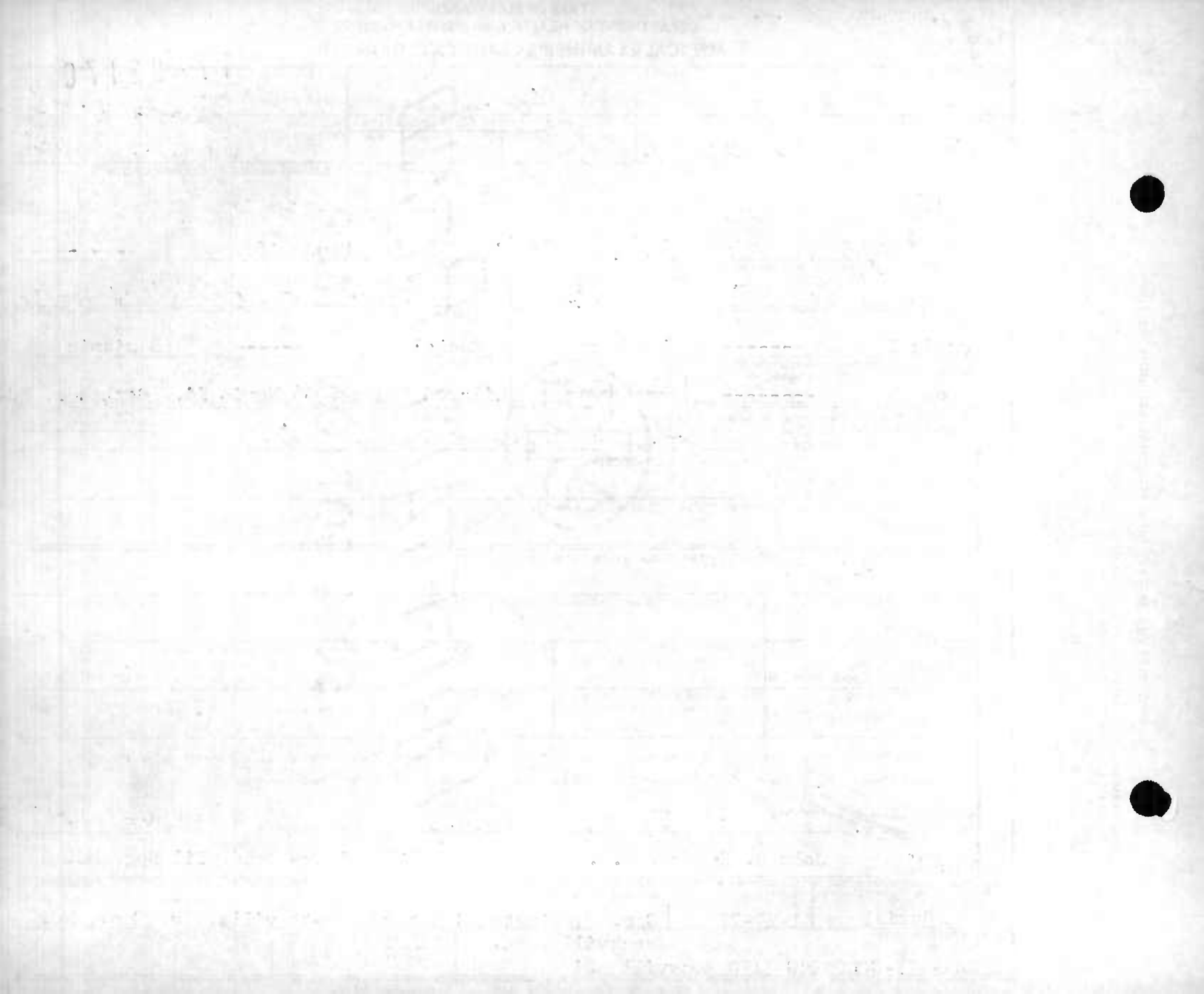
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 16b, please call w/F.H. 2/27/77 kam										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 7-02170	
1- STATE REGISTRAR										2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		HOUR MIN	
1. DECEASED NAME (TYPE OR PRINT) <b>Jennie Lerner</b>										2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		HOUR MIN	
2. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 28 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		7c. DATE PRONOUNCED DEAD <b>Jan 25 1977</b>		2d. HOUR MIN <b>11 00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>England</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>			
10. CITY OR TOWN OF DEATH <b>Si. Spg.</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1401 Blair Mill Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			
13a. STATE <b>MD</b>				13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>Si. Spg.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1401 Blair Mill Rd Apt 301</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Morris ----- Isenberg</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rachel ----- Benjamin</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>							
16b. SOCIAL SECURITY NO. <b>182-07-2088</b>				17. INFORMANT <b>Mildred Rosen 7006 Nevis Rd., Bethesda, Md</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>428X</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b). <b>None</b>							
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>Dep.</b> M.D. <b>Dep.</b> MEDICAL EXAMINER				DATE SIGNED <b>Jan 25 1977</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>1919 Seminary Road, Sil Spg, Md.</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1-27-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Washington Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hyattsville, Pr. Geo., Md.</b>					
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG</b>				ADDRESS <b>1170 Rockville Pike</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1977</b>				25b. REGISTRAR'S SIGNATURE <b>John S. Rogers</b>			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

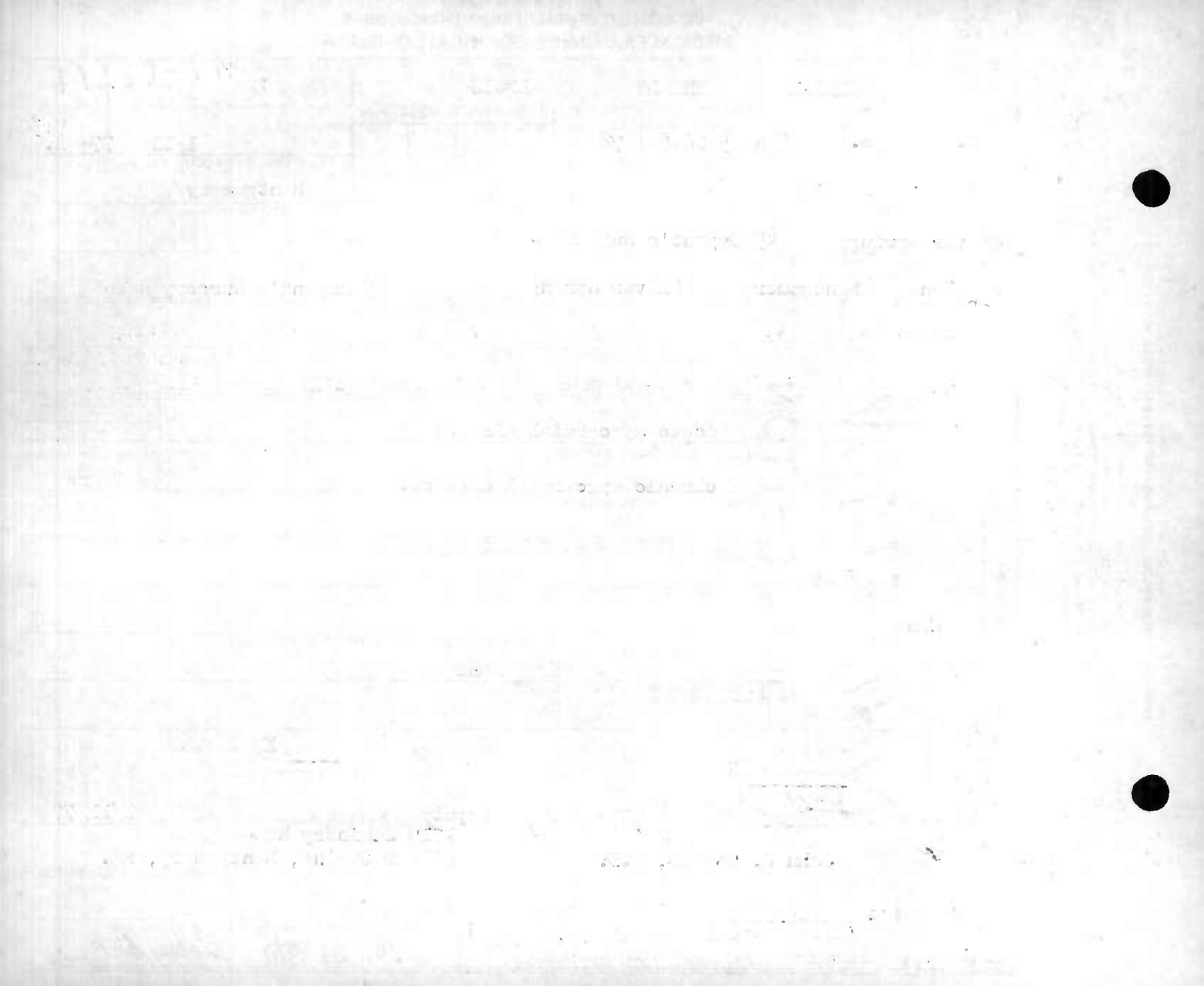
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
FIRST MIDDLE LAST WILLIAM EBERLY LEWIS		DATE KNOWN OF DEATH ESTI. MATED <input checked="" type="checkbox"/> 1/11 1977	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
M.	W.	MONTH DAY YEAR 8 5 1898	LAST BIRTHDAY 78 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
Washington, D.C.		U.S.A.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Silver Spring		45 Bryant's Nursery Road	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Dentist			
13a. STATE		13b. COUNTY	
Maryland		Montgomery	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS		13f. STREET ADDRESS	
		45 Bryant's Nursery Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST William V. Lewis		FIRST MIDDLE LAST Maude Elizabeth Eberly	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Yes		W.W.1 577-54-0850	
17. INFORMANT		ADDRESS	
Harold Lewis, 1617 Irving St., N.E.,		Wash. D.C. 20018	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u>			
DUE TO, OR AS A CONSEQUENCE OF			
(b) <u>chronic myocardial disease.</u>		Years	
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
None			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
None			
20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
		None	
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> inspection <input type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		None	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Cremation		1/15/77	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Fort Lincoln Crematory		Brentwood, Maryland	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
Hines/Rinaldi Funeral Home, Inc.		JAN 21 1977	
11800 New Hampshire Ave., Silver Spring, Md.		25b. REGISTRAR'S SIGNATURE	
		History McQuay	

MEDICAL CERTIFICATION

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										77-02172 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
Joseph D. Libbey III								X MONTH DAY YEAR 1 1 19 77		M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD	
Male	White	1 23 49		27 YRS.						1 1 19 77 5:40 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Montgomery County MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring		Holy Cross Hospital				Carpenter - self employed					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		Montgomery		Silver Spring				12815 Two Farm Drive			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Joseph D. Libbey, Jr.		Ruth Brightman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No		219-54-8266		Joseph D. Libbey, 2329 Porter St., N.W., D.C.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Multiple injuries											
8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:30 xxx 1 1 19 77		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				Driver of auto in fixed object collision							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE E. Randolph Rd. Montgomery Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural Causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER				DATE SIGNED 1/2/77			
EXAMINER'S NAME (TYPE OR PRINT)		Hormez R. Guard, M.D.		ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Cremation		1/3/77		Fort Lincoln Crematory		Brentwood, Maryland					
24. FUNERAL DIRECTOR NAME		Hines/Rinaldi Funeral Home, Inc.		24b. REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
11800 New Hampshire Ave., S. S., Md.				JAN 7 1977		Pierney McCreedy					

11-82173

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Corporation - with approval

111-82173-25-8256 Joseph D. Lindey, 2325  
111-82173-25-8256 Joseph D. Lindey, 2325  
111-82173-25-8256 Joseph D. Lindey, 2325



111-82173-25-8256 Joseph D. Lindey, 2325  
111-82173-25-8256 Joseph D. Lindey, 2325  
111-82173-25-8256 Joseph D. Lindey, 2325

DHMH - 17  
(VR A15 ME (5))  
30M 7/73



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO. 77-02172

1. DECEASED NAME (TYPE OR PRINT) <i>Dean Ronald Long</i>		FIRST <i>Dean</i>		MIDDLE <i>Ronald</i>		LAST <i>Long</i>		20. DATE KNOWN OF DEATH ESTI- MATED <input type="checkbox"/> <i>Jan 23 1977</i>		2b. HOUR <i>6:30</i>	
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH <i>1</i> DAY <i>15</i> YEAR <i>1917</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>59</i> YRS.	IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i>	IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>	7c. DATE PRONOUNCED DEAD <i>Jan 23 1977</i>		2b. HOUR <i>6:30</i>		2b. HOUR <i>6:30</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>PENNSYLVANIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>		MD			
10. CITY OR TOWN OF DEATH <i>Rock Park</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist St Hosp</i>		12a. USUAL OCCUPATION (TYPE OF WORK) <i>ACCOUNTANT</i>		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13b. COUNTY <i>Prince George's</i> 13c. CITY OR TOWN <i>Rock Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1305 16th Ave</i>							
14. FATHER'S NAME FIRST <i>CHARLES</i> MIDDLE <i>LONG</i>		15. MOTHER'S MAIDEN NAME FIRST <i>CARRIE</i> MIDDLE <i>HAWK</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>YES</i> (IF YES, GIVE WAR OR DATES) <i>WW II</i>		16b. SOCIAL SECURITY NO. <i>578-10-6359</i>		17. INFORMANT <i>HELEN B. LONG</i>		ADDRESS <i>SAME AS 13</i>		<i>WIFE</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis</i> <i>438X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) <i>Chronic Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>None</i>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M.</i> <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET <i>SILVER SPRING, MARYLAND</i>		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <i>Dep.</i>		M.D. <i>Dep.</i>		MEDICAL EXAMINER		DATE SIGNED <i>Jan 23 1977</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS</i>		ADDRESS <i>SILVER SPRING, MARYLAND</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>1/26/77</i>		23c. NAME OF CEMETERY OR CREMATORY <i>FT. LINCOLN CEMETERY</i>		23d. LOCATION CITY OR TOWN <i>BRENTWOOD</i>		COUNTY <i>PRINCE GEO</i>		STATE <i>MD.</i>	
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>		ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD 20901</i>		25a. DATE REC'D. BY REGISTRAR <i>JAN 26 1977</i>		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>					

10-10-10

10-10-10

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										SALVATORE LOSCHIAVO, JR. REG. NO.																																							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Salvatore Loschiavo Jr.										2a. DATE KNOWN OF DEATH MONTH DAY YEAR JAN 17 1977										2b. HOUR OF DEATH M 11:15																																							
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2 1 49			6. AGE (IN YEARS) LAST BIRTHDAY 27 YRS.			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD JAN 17 1977										2d. HOUR M 8:00																																			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C. U. S. A.				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.																																															
10. CITY OR TOWN OF DEATH Tak Park				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6718 Cackerille Ave Tak. Pk.										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CUSTOM AUTO TOP INSTALLATION										12b. KIND OF BUSINESS OR INDUSTRY																																			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE Md										13b. COUNTY Mont										13c. CITY OR TOWN Tak Park										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 6718 Cackerille Ave									
14. FATHER'S NAME FIRST MIDDLE LAST Salvatore Loschiavo. Sr.										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Cortalano.										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes.										16b. SOCIAL SECURITY NO. 216-50-5176										17. INFORMANT Mrs. Anna Loschiavo. (Mother)										ADDRESS 13 e									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 955X IMMEDIATE CAUSE (a) Gunshot Wound of Head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None																																																											
19a. DATE OF OPERATION None										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10:30 1 17 1977										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot self																																							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home										21f. LOCATION STREET CITY OR TOWN COUNTY STATE Cackerille Ave Tak Park Mont Md																																							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																																											
ACTUAL SIGNATURE J. P. Rogers										TITLE (SPECIFY) M.D. Asst. MEDICAL EXAMINER										DATE SIGNED JAN 17 1977																																							
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																																																	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23a. DATE Jan 20-77										23b. NAME OF CEMETERY OR CREMATORY St. Lincoln										23c. LOCATION Baltimore, Md.																													
24. FUNERAL DIRECTOR Name Debra Walters										25a. DATE REC'D. BY REGISTRAR JAN 20 1977										25b. REGISTRAR'S SIGNATURE Anthony McCreedy																																							

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										77-02175 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)		FIRST EINAR		MIDDLE NMN		LAST LUDVIGSEN		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1/28 1977		2b. HOUR M					
3. SEX M.	4. RACE W.	5. DATE OF BIRTH MONTH DAY YEAR 6 22 08		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 1/28 1977		2d. HOUR 9:15 A.M.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Norway		7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.								
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10110 New Hampshire Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction							
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Apt. # 201 10110 New Hampshire Avenue							
14. FATHER'S NAME FIRST MIDDLE LAST Hans Joseph Ludvigsen		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Magdalena Peterson				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO						16b. SOCIAL SECURITY NO. 136-05-9600		17. INFORMANT ADDRESS (same as 13 a,b,c,d,e) Mrs. Vera L. Ludvigsen (Wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER				DATE SIGNED 1/28/77							
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS 1919 Seminary Road Silver Spring, Montgomery, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 31 Jan. 1977		23c. NAME OF CEMETERY OR CREMATORY George Washington				23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville Prince Georges, Md							
24. FUNERAL DIRECTOR NAME HINES/RINALDI FUNERAL HOME		ADDRESS 11800 New Hampshire Ave Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR FEB 3 1977		25b. REGISTRAR'S SIGNATURE <i>Henry McCready</i>									

DHMH-17  
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 77-62176	
1. DECEASED NAME (TYPE OR PRINT) <b>Wilhelmina Ludwig</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1 12 9 77					
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 2 1913</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>63 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>1 15 9 77</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>218 Newmark Esplanade</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Assoc. to Pres. Sav. &amp; Loan Banking</b>			
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>218 Newmark Esplanade</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles J Ludwig</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Catherine M Drummer</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>578-24-1325</b>		17. INFORMANT <b>Sister</b> ADDRESS <b>Col. 80302 Doris L Allen, 1430 Moss Rock Pl., Boulder,</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac tamponade</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>ruptured dissecting aneurysm of aorta</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Non-fatal trauma</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Thomas D. Smith</b>				TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>1/16/77</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>1/18/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS, INC.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>			



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to the... of the...

Charles  
1984-1985  
John A. Allen, 1980-1984, 1985-1986  
Col. 8005

11

of the... will be...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02177

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		January 30 1977		500 A M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		MONTH DAY YEAR June 1 1938		38	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Connecticut		USA				Montgomery MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		National Naval Medical Center		Housewife		Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Virginia		Pr. William		Woodbridge		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Kenneth Irving Culver		Matilda Harold		No		048 30 1582	
17. INFORMANT		ADDRESS		17. INFORMANT		ADDRESS	
James M. Maine		See item 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Multiple cavitory lesions (Pulmonary)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aspergillus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Carcinoma of the lung					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 21</u> , 19 <u>76</u> , to <u>Jan. 30</u> , 19 <u>77</u> , that I (we) lost saw the deceased alive on <u>Jan. 30</u> , 19 <u>77</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. If (we) did (did not) view the body after death.		22b. SIGNATURE <u>M. McCance LTMC USNR</u> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>Jan. 31, 1977</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. McCance, LT MCUSNR		22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 3, 1977		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Norwich New London Conn.	
24. FUNERAL DIRECTOR NAME Rob't. A. Pumphrey Funeral Home, Bethesda, Md.		ADDRESS		25. DATE REC'D. BY REGISTRAR FEB 3 1977		SIGNATURE OF REGISTRAR <u>Robert McCance</u>	

BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02178

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Elsie M. Mangum</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 24 77</b>		2b. HOUR <b>9:05 AM</b>						
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 27 1890</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co</b> MD.					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret coordinator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Printing</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Takoma Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7601 Hammond Ave</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl E Grothey</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sophia W. Freyer</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>216 01 4960A</b>		17. INFORMANT ADDRESS <b>Mrs. Eloise M. Samaha Same</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>5 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>October</b> , 19 <b>76</b> , to <b>January 24</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>Jan 24</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Keith M Lindgren</b> MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>1/24/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Keith M Lindgren</b>						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/26/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemt.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brooklyn AA Md</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Mitchell-Wiedefeld Home 6500 York Rd.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1. STATE REGISTRAR		#2a, Film 506 4/11/77 kam		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		77-02179 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>NAOMI F. MANN</b>				2a. DATE OF DEATH MONTH <b>1</b> DAY <b>2</b> YEAR <b>77</b>		2b. HOUR <b>7 30 PM</b>	
3 SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>17</b> YEAR <b>1895</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Montgomery</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>12412 Green Hill Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>U.S. Government</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Silver Spring</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12412 Green Hill Drive</b>	
14 FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Pries</b> LAST <b>Pries</b>				15 MOTHER'S MAIDEN NAME FIRST <b>Kate</b> MIDDLE <b>Urban</b> LAST <b>Urban</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>223-60-6345</b>		17 INFORMANT ADDRESS <b>David L. Mann, 315 Park Dr., Palatine, Ill.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA - UTERINE CERVIX</b> 180X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>METASTASES - DIFFUSE</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (18a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-10</b> , 19 <b>75</b> , to <b>1-2</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>12-29</b> , 19 <b>76</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>L. McGowan, M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1-2-77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>L. McGowan, M.D.</b>				22e. ADDRESS <b>7625 Mary Cassatt Dr., Potomac, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/5/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Arlington</b> COUNTY <b>Virginia</b> STATE	
24. FUNERAL DIRECTOR NAME <b>HINES/RINALDI F.H.</b>				11800 New Hampshire Ave <b>Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 7 1977</b>	
				25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>			

17-0212

W. M. M. M.

Aug. 17-1902

Montgomery

U.S. Government

Small Green Hill Drive

Urban

Price

Price

Price

17-0212 David E. Mann, 115 East Dr., Baltimore, Md.

to

17-0212 David E. Mann, 115 East Dr., Baltimore, Md.

17-0212 David E. Mann, 115 East Dr., Baltimore, Md.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										77-02180 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Constance B. Marcy</b>						2a. DATE KNOWN OF DEATH		2b. DATE ESTI- MATED		2c. DATE PRONOUNCED DEAD	
3. SEX <b>Fe.</b>						4. RACE <b>W.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6-3-1899</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>77 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4615 North Park Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4615 North Park Rd.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Bookminster</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Alice E. Miller</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>579 60 4355</b>			17. INFORMANT <b>Constance Merwin-grand daughter</b> ADDRESS <b>2801 New Mexico Ave N.W. Wash. D.C. 20007</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency Acute</b> <b>1124</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Cardiovascular Disease -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cirrhosis of Liver</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic Alcoholism</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>John G. Bell</b>			TITLE (SPECIFY) <b>Deputy</b>			MEDICAL EXAMINER			DATE SIGNED <b>Jan. 15, 1977</b>		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>1-17-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>			23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>Funeral Home</b>						25a. DATE REC'D. BY REGISTRAR <b>Jan 20 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCreedy</b>			

560 BP



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

77-02181

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lucy KNOX Marie			2a. DATE OF DEATH MONTH DAY YEAR 1 5 77			2b. HOUR 6:05 P M	
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 6 90		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Guthrie Woodland Nsg Hm		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. CITY OR TOWN AA		13c. STREET ADDRESS Edge water	
14. FATHER'S NAME FIRST MIDDLE LAST Douglas Hamilton Knox				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Brockenborough Knox			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-44-1500		17. INFORMANT ADDRESS Mrs John Clagett 4804 College Ave College Park, Md. 20740			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Vascular Disease</u> 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  
Sensitization

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 17</u> , 19 <u>67</u> , to <u>1-5</u> , 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>1/5</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Bernard A. Fitzerald</u> M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/5/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. FITZGERALD				22e. ADDRESS 27 UNIVERSITY BLVD EAST, SILVER SPRING, MD.			

23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 1/7/77		23c. NAME OF CEMETERY OR CREMATORY USNA A. CENT		23d. LOCATION HAWTHORNS AA MD.	
24. FUNERAL DIRECTOR John M. Fitzerald				25a. DATE REC'D. BY REGISTRAR JAN 10 1977		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

22

10/17

House to Home

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10/17/1917



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH - 16 50M 1/76  
(VR A 15 (4))



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO. 77-02182							
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH MONTH DAY YEAR	
Verda		L.		MARK				JAN 29 1977 8:15 A M	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Jan. 20, 1883		94 YRS.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Virginia		U.S.A.				Montgomery MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Bel Pre' Nursing Home				Housewife			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS	
Maryland		Montgomery		Damascus				25929 Woodfield Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				
Joseph - Sandy					Frances - Hollar				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS		
No					286-05-3386-D		Robert G. Tuckerman, Item 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure									
174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) Adenocarcinoma of breast									
(c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (his hospital) attended the deceased from 19 to 1-29-77, that (1) (he) lost									
saw the deceased alive on 11-29-77, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (2) (did) (did not) view the body after death.									
22b SIGNATURE		DEGREE				22c DATE SIGNED			
John G. Lodmell MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				11/29/77			
22d PHYSICIAN'S NAME (TYPE OR PRINT)				22e ADDRESS					
JOHN G. LODMELL MD				18111 PRINCE PHILIP DR OLNEY MD 20832					
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION CITY OR TOWN COUNTY STATE			
Cremation		Jan. 31, 1977		Westview		Baltimore, Md.			
24 FUNERAL DIRECTOR NAME				ADDRESS		25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Olin L. Molesworth, Damascus, Md.						FEB 2 1977		[Signature]	

BP



17-02-82

(M)

19	Jan. 20, 1953	White	Female
Montgomery	x	U.S.A.	Virginia
Housewife		Bel Air, Maryland	River Spring
15029 Woodfield Dr.	x	Montgomery	Virginia
10/10	-	Andy	-
13	10-02-1953	10-02-1953	0

10/10 10-02-1953 10-02-1953 0



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CORONER NOTIFIED

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02183 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
ANTHONY						MAR SANOPOLI		1		21	77	6:30	A.M.
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		White		MONTH 11 DAY 7 YEAR 90		86		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Italy		U.S.A.				MONTGOMERY						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
SILVER SPRING		HOLY CROSS HOSPITAL		Self employed		barber							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		Montg.		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		10407 Amherst Avenue					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
Biaggio		Marsanopoli		Anna		Gregorio							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS							
No		577-44-9094		Josephine C. Marsanopoli, see #13									
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <u>Pneumonia</u> 486X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: } (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Uncontrolled Heart Disease</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> 19 <u>77</u> to <u>1/20</u> 19 <u>77</u> , that (I) <u>have</u> lost saw the deceased alive on <u>1/20</u> 19 <u>77</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>have</u> (did not) view the body after death.		22b. SIGNATURE <u>Richard C. Cloth</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>1/21/77</u>							
22d. THIS DEATH'S NAME (TYPE OR PRINT) <u>R. Cloth</u>		22e. ADDRESS <u>Silver Spring, Maryland</u> <u>10620 Georgia Ave</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>1/24/77</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring, Md.</u>							
24. FUNERAL DIRECTOR NAME <u>Hines/Rinaldi</u>		ADDRESS <u>Funeral Home</u> <u>11800 New Hampshire Ave., Silver Spring, Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>JAN 27 1977</u>		25b. REGISTRAR'S SIGNATURE <u>Anthony M. Brady</u>							

11-02183

11-02183

11-02183

11-02183

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		77-02184 REG. NO.											
I. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR			
MAR GARATE		H.				MARSCHNER		1-22-77		5:30A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
FEMALE		White		March 14, 1887		89		MONTHS		DAYS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Germany		Germany				Montgomery				MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Brooke Grove Foundation						H. wife		Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13c. STREET ADDRESS							
13a. STATE Maryland				13b. COUNTY Montgomery		YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS BROOK GROVE RD.					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST Feodor - Scheibe				FIRST MIDDLE LAST Marie Hasenmeyer									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No						Brigitte Bartels		627 Houston Ave. Takoma Park, Md. 20012					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4/124 IMMEDIATE CAUSE (a) Cordain Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH seconds			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD		4RS	
										DUE TO, OR AS A CONSEQUENCE OF (c) General Cerebral Vasc. Disease		7RS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) schubert													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
NM		nd				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1977, to 1/21, 1977, that (I) (we) lost saw the deceased alive on 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
Melvin J. Gordon								1/22/77					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
Melvin J. Gordon				15 E PEER P.K. DR. Gaithersburg Md. 20760									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
Cremation		Jan. 23, 1977		Lee Funeral Home				Washington, D. C.					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis H. Barber				Laytonsville, Md. 20760				JAN 27 1977		Therapy McCreedy			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02186  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Joubert</b>		FIRST <b>JOUBERT</b> MIDDLE		LAST <b>MASTBROOK</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>January 18, 1977</b>			2b. HOUR <b>6<sup>22</sup> A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 19 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>						
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bldg. Contractor</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>101 Southbrook Lane</b>		
14. FATHER'S NAME <b>William</b> MIDDLE LAST <b>Mastbrook</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Helen</b> MIDDLE LAST <b>Leighkite</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW1</b>		17. INFORMANT <b>Daughter</b> ADDRESS <b>Germantown, Md.</b>			17. INFORMANT <b>Margie M. Whipp</b> 19515 <b>Frederick Road</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>428X</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MYOCARDIAL HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>7 YRS</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HR</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b):												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 19 70</b> to <b>JAN 19 77</b> , that (I) (we) lost saw the deceased alive on <b>11/12/77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>DR. LEO J. DENOVAN</b>						DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/18/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. LEO J. DENOVAN</b>						22e. ADDRESS <b>8218 Wisconsin Ave Bethesda</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/22/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Norbeck Memorial Park</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Olney, Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS INC.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Pitney/KCready</b>				

MEDICAL CERTIFICATION

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page of vol.

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D.M.

11-10-1964

Н. П. С.

• ON TWO THINGS

1952-1953

92-5-05-552

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On 12/14/1994, 1995

## 2. Introduction

WFL/SI/I



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DDMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02187

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Roberto Jose Mayorga		male		white	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE PRONOUNCED DEAD	
2-8-1938		38 YRS.		1 20 1977	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	
NICARAGUA		U. S. A.		XX NEVER MARRIED	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION	
Silver Spring		Holy Cross Hospital		ACCOUNTANT-AMERICAN COLLEGE OF CARDIOLOGY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Va.		LOUDOUN		Sterling Park	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	
ENRIQUE MAYORGA		MERCEDES MOREIRA		YES	
16b. SOCIAL SECURITY NO.		17. INFORMANT (WIFE)		18. CAUSE OF DEATH	
563-52-3887		HELGA D. MAYORGA		885X	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES X NO	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED	
UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH		P.M. 1 15 19 77		fell on ice	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION	
WHILE AT WORK X NOT WHILE AT WORK		street		Rockville Pike Bethesda Mont. Md.	
22a. I certify that I took charge of the remains described above, held an		Autopsy X Inspection Inquiry and in my opinion		death resulted from	
Natural causes Accident X Homicide Undetermined manner		TITLE (SPECIFY)		DATE SIGNED	
ACTUAL SIGNATURE		M.D. Assistant		1/21/77	
EXAMINER'S NAME		ADDRESS		23a. BURIAL, CREMATION, REMOVAL	
Thomas D. Smith, M.D.		111 Penn Street		REMOVAL-BURIAL	
23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
1/25/1977		STERLING CEMETERY		STERLING, LOUDOUN COUNTY, VA.	
24. FUNERAL HOME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
GREEN FUNERAL HOME, HERNDON, VIRGINIA		JAN 26 1977		Barney McCreedy	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		77-02188				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		THOMAS JACKSON McDOWELL				2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
THOMAS J McDOWELL		3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)	
Male		White		August 23 1884		92		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BIRTHPLACE CITY OR COUNTY OR STATE		12b. KIND OF BUSINESS OR INDUSTRY	
Virginia		U. S. A.				Montgomery County		U. S. Gov't.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN HOME)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hospital		Gen. Act. Off.					
13a. STREET ADDRESS		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
District of Columbia		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		510 Nicholson St. N. W.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Thomas		Mary Elizabeth Blake		No		578-24-2188		Mrs. Margaret Wydro	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:	
2509		Pneumonia		2509		Pneumonia		2509	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Diabetic Mellitus		Diabetic Mellitus		Diabetic Mellitus		Diabetic Mellitus		Diabetic Mellitus	
DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF	
Urinary Tract Infection		Urinary Tract Infection		Urinary Tract Infection		Urinary Tract Infection		Urinary Tract Infection	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):	
Organic Brain Syndrome - Similarity 92 yrs old		Organic Brain Syndrome - Similarity 92 yrs old		Organic Brain Syndrome - Similarity 92 yrs old		Organic Brain Syndrome - Similarity 92 yrs old		Organic Brain Syndrome - Similarity 92 yrs old	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-2, 1977, to 1-13, 1977, that (I) (we) last saw the deceased alive on 1-12, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22c. DATE SIGNED		22c. DATE SIGNED	
		Roland Imperial M.D.		1-13-77		1-13-77		1-13-77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS		22f. ADDRESS		22f. ADDRESS	
Roland Imperial M.D.		4977 BATTERY LANE		4977 BATTERY LANE		4977 BATTERY LANE		4977 BATTERY LANE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Jan. 15, 1977		Oakwood Cemetery		Richmond, Virginia		Richmond, Virginia	
24. FUNERAL DIRECTOR NAME		24. FUNERAL DIRECTOR NAME		24. FUNERAL DIRECTOR NAME		24. FUNERAL DIRECTOR NAME		24. FUNERAL DIRECTOR NAME	
JOSEPH GAWLER'S SONS INC.		JOSEPH GAWLER'S SONS INC.		JOSEPH GAWLER'S SONS INC.		JOSEPH GAWLER'S SONS INC.		JOSEPH GAWLER'S SONS INC.	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
JAN 24 1977		Anthony McCreedy		Anthony McCreedy		Anthony McCreedy		Anthony McCreedy	

BP

88-101-10

RECEIVED

White

1914

Montgomery County

x

U. S. A.

Montgomery County

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

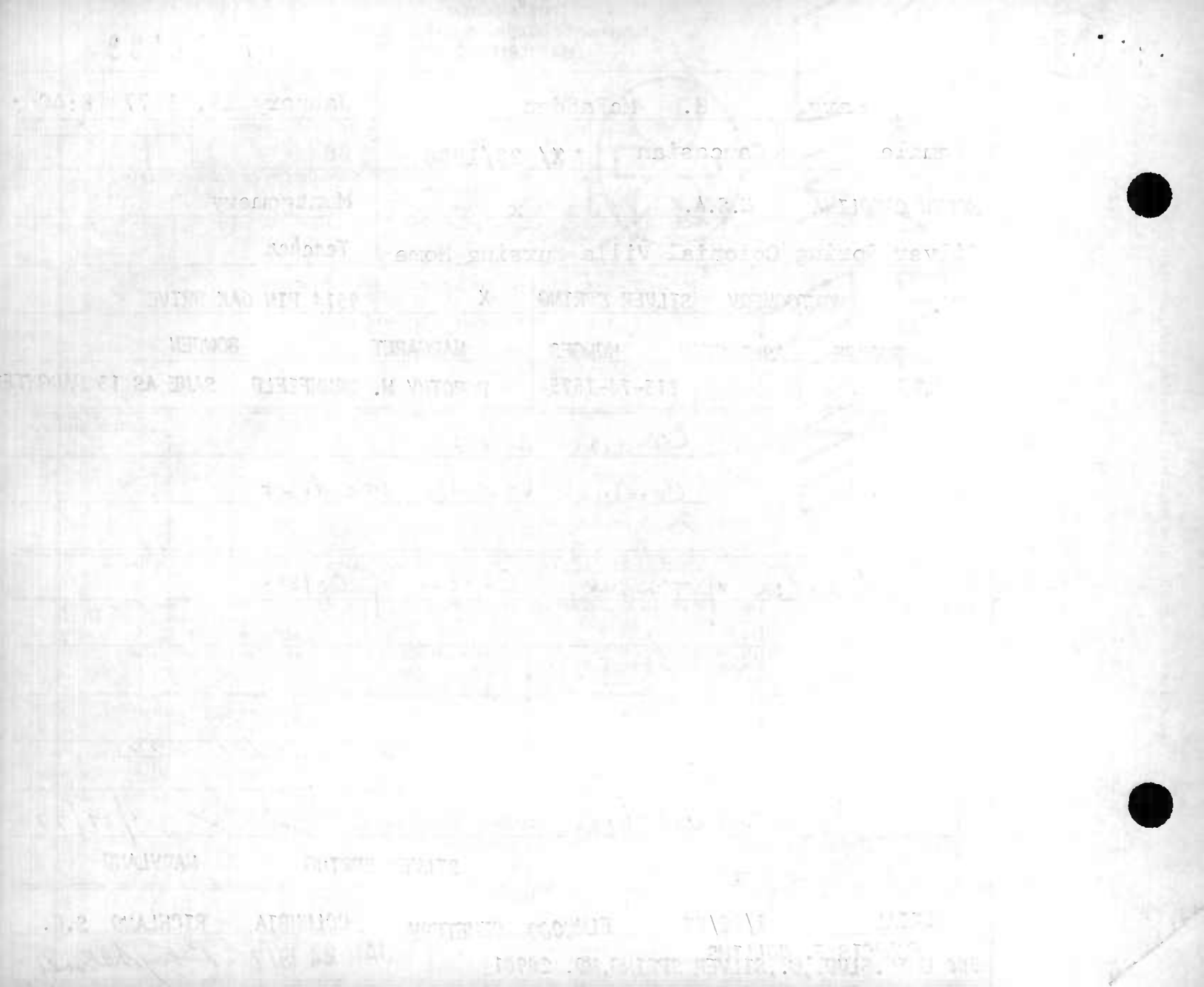
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02189

1. DECEASED NAME (TYPE OR PRINT) <b>Mary H. McFadden</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 19, 1977</b>			2b. HOUR <b>8:40<sup>A.</sup></b>			
3 SEX <b>female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 X/ 25/1888</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>88</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SOUTH CAROLINA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD			
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Colonial Villa Nursing Home</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE <b>MD.</b>			13b COUNTY <b>MONTGOMERY</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS <b>9514 PIN OAK DRIVE</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE WASHINGTON HODGES</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET BOWDEN</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>213-74-1575</b>		17 INFORMANT ADDRESS <b>DOROTHY M. BRUMFIELD SAME AS 13 DAUGHTER</b>				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: <b>4369 Cardiac Arrest.</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cancer of Tongue Cancer of Colon</b>									
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1/19</b> , 19 <b>76</b> , to <b>1/19</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>1/14</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>F. J. Semelch</b>					DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>1/19/77</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>F. J. Semelch</b>					22e. ADDRESS <b>SILVER SPRING MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/22/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ELMWOOD CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>COLUMBIA RICHLAND S.C.</b>		
24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 1/75  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02190

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3 SEX		4 RACE	
FIRST MIDDLE LAST		Male		Cauc.	
5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
March 6, 1904		72 YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Pennsylvania		USA			
9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
Montgomery MD.		Bethesda		Suburban Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS	
Attorney		Private Prac		4100 W St. N.W.	
13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? (YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS	
Washington, D.C.				4100 W St. N.W.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	
James Lee McFate		Esther Ray		No	
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
171-12-2198		Harriet M. McFate		4100 W St. N.W. Washington, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u> (b) <u>Status post colon interposition</u> (c) <u>Obstructing Ca upper rectum post resection</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>atherosclerotic Cardiovascular disease</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
1-24-77		Ca resection post resection		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>1-22-77</u> 19 <u>77</u> to <u>1-23-77</u> 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>1-23-77</u> 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
V.C. De Guzman MD		MD		1-24-77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR	
V.C. De Guzman MD		1234 19NW WASH DC		22g. REGISTRAR'S SIGNATURE	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		1-25-77		Cedar Hill Crematory	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		24c. DATE REC'D. BY REGISTRAR	
Murphy Funeral Homes-Arl.		4510 Wilson Blvd. Arlington, Va.		24d. REGISTRAR'S SIGNATURE	
		24e. DATE REC'D. BY REGISTRAR		24f. REGISTRAR'S SIGNATURE	
		JAN 26 1977		P. J. McCreedy	

BP

03-10-21





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

0803BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

77-02191

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy Cleopatra Mc Ghee</b>			2a. DATE OF DEATH MONTH <b>JAN</b> DAY <b>1</b> YEAR <b>1977</b>			2b. HOUR <b>7:00</b> P.M.		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>23</b> YEAR <b>1920</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Germantown</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>20300 Frederick Rd.</b>		
14. FATHER'S NAME FIRST <b>Junie</b> MIDDLE <b>F.</b> LAST <b>Hawkins</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Dora</b> MIDDLE <b>-</b> LAST <b>Coffey</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>226-26-3310</b>		17. INFORMANT ADDRESS <b>Elton T. McGhee, Item 13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal arrhythmia &amp; Cardiac Arrest</b> <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Due to Myocardial Infarction with adhesion</b> (c) <b>Chronic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 mins</b> <b>48 hours</b> <b>8 years</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OF WHICH IT IS A PART <b>Severe Rheumatoid Arthritis, Long Term Steroid Therapy, with</b>								
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>1968</b> to <b>1/1/77</b> , that (I) (we) lost saw the deceased alive on <b>1/1/77</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Frederick S. Chapman</b> DEGREE <b>MD</b>				22c. DATE SIGNED <b>1/2/77</b>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FREDERICK S. CHAPMAN</b>		
22e. ADDRESS <b>604 TERRY BLVD</b>				22f. ADDRESS <b>ROCKVILLE MD. 20852</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 4, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bedford, Bedford, Va.</b>		
24. FUNERAL DIRECTOR NAME <b>Olin L. Molesworth, Damascus, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy McGhee</b>		

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THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
#8, Film G504 2/18/77 kam 1- STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) <b>Richard F. McGrath</b>					2a. DATE OF DEATH MONTH <b>January</b> DAY <b>3</b> YEAR <b>1977</b>		2b. HOUR <b>1:00 A</b> M		
3 SEX <b>Male</b>		4 RACE <b>white</b>		5. DATE OF BIRTH MONTH <b>May</b> DAY <b>28</b> YEAR <b>1915</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Test Consultant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. STATE <b>Md.</b> 13b. COUNTY <b>Montg.</b> 13c. CITY OR TOWN <b>Germanstown</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>20241 Laurel Hill Way</b>		
14. FATHER'S NAME FIRST <b>Dennis</b> MIDDLE <b></b> LAST <b>McGrath</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Dorothy</b> MIDDLE <b></b> LAST <b>Lutz</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT ADDRESS <b>Kathleen McGrath #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>486X</b> IMMEDIATE CAUSE (a) <b>coronary insufficiency</b> <b>acute MI</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b>	
DUE TO, OR AS A CONSEQUENCE OF <b>acute MI</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>RUL pneumonia</b>								2 days	
DUE TO, OR AS A CONSEQUENCE OF <b>left heart failure</b> (c) <b>coronary artery disease</b>								?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>1/2</b> 19 <b>77</b> to <b>1/3</b> 19 <b>78</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>1/2</b> 19 <b>77</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> (did) (did not) view the body after death.									
22b. SIGNATURE <b>Gregor</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/3/78</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gregor</b>				22e. ADDRESS <b>12105 Carnestown Rd md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1-4-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN <b>Alexandria</b> COUNTY <b>Va</b> STATE <b>Va</b>			
24. FUNERAL DIRECTOR NAME <b>Forre A. Sandison</b>		ADDRESS <b>316 E Diamond</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Dorothy McBrady</b>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

#5, Per call w/Daugh. 2/9/77 kam #12b, Film G504 2/18/77 DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										77-02193 REG. NO.																								
1. DECEASED NAME (TYPE OR PRINT)			FIRST John.			MIDDLE ALBERT			LAST McIntire			2b. DATE KNOWN OF DEATH ESTIMATED			MONTH 1			DAY 23			YEAR 1977			2d. HOUR 6A										
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH 11		DAY 4		YEAR 1907		6. AGE (IN YEARS (LAST BIRTHDAY)) YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		HOURS		MIN		7c. DATE PRONOUNCED DEAD			MONTH Jan			DAY 23			YEAR 1977			2d. HOUR 9A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD																						
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5317 Carvel Rd										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer				12b. KIND OF BUSINESS OR INDUSTRY U.S. Govern.																
13a. STATE Md.										13b. COUNTY Montgomery			13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 5317 Carvel Rd															
14. FATHER'S NAME FIRST John					MIDDLE D.					LAST McIntire					15. MOTHER'S MAIDEN NAME FIRST Belle					MIDDLE Parker					LAST Parker									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WV 11					17. INFORMANT ADDRESS 579-44-1125 ELSIE W. McINTIRE-5317 CARVEL RD					BETHESDA, MD																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4124 IMMEDIATE CAUSE (a) Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																		
ACTUAL SIGNATURE John G. Ball					TITLE (SPECIFY) M.D. Deputy					MEDICAL EXAMINER					DATE SIGNED Jan 23 1977																			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball					ADDRESS 7936 Old Georgetown Rd., Bethesda, Md.																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal					23b. DATE Jan. 23, 1977					23c. NAME OF CEMETERY OR CREMATORY George Washington University Medical School, Wash. DC					23d. LOCATION CITY OR TOWN COUNTY STATE																			
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER'S SONS INC.										25a. DATE REC'D. BY REGISTRAR JAN 26 1977										25b. REGISTRAR'S SIGNATURE Rafael McCredy														

57-0000

THE OFFICE OF THE ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE, JANUARY 1, 1900.

REPORT OF THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



# STATE OF MARYLAND

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO. 77-02

1. DECEASED NAME (TYPE OR PRINT) <i>Lillian Caroline Meyer</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>Jan. 2nd. 1977</i>		2b. HOUR <i>7:35</i> M				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 15 1892</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>84</i> YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Indiana</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD			
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>7053-Wolftree Rd.</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <i>Md.</i>				13b. COUNTY <i>Montg.</i>		13c. CITY OR TOWN <i>Rockville</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ernest Linhardt</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Caroline Schacher</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>				16b. SOCIAL SECURITY NO. <i>214-74-5024</i>		17. INFORMANT ADDRESS <i>Helen M. Winkelman 7053-Wolftree Rd. Rockville, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial failure</i> <i>4123</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Gastrointestinal Bleeding</i>									
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>May 1968</i> to <i>present</i> , 19 <i>77</i> , that (I) (we) lost saw the deceased alive on <i>12/31</i> 19 <i>76</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John B. Clarkson MD</i>						22c. DATE SIGNED <i>1/2/77</i>		22d. ADDRESS <i>8805 Penn. Ave., Chevy Chase, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>1/6/77</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. John Eva. Lut. Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Fort Wayne Ind.</i>		
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi F.H. Inc.</i>			25. ADDRESS <i>11800 N.H. Ave.</i>			26. DATE REC'D. BY REGISTRAR <i>JAN 10 1977</i>		27. REGISTRAR'S SIGNATURE <i>Patricia McCready</i>	

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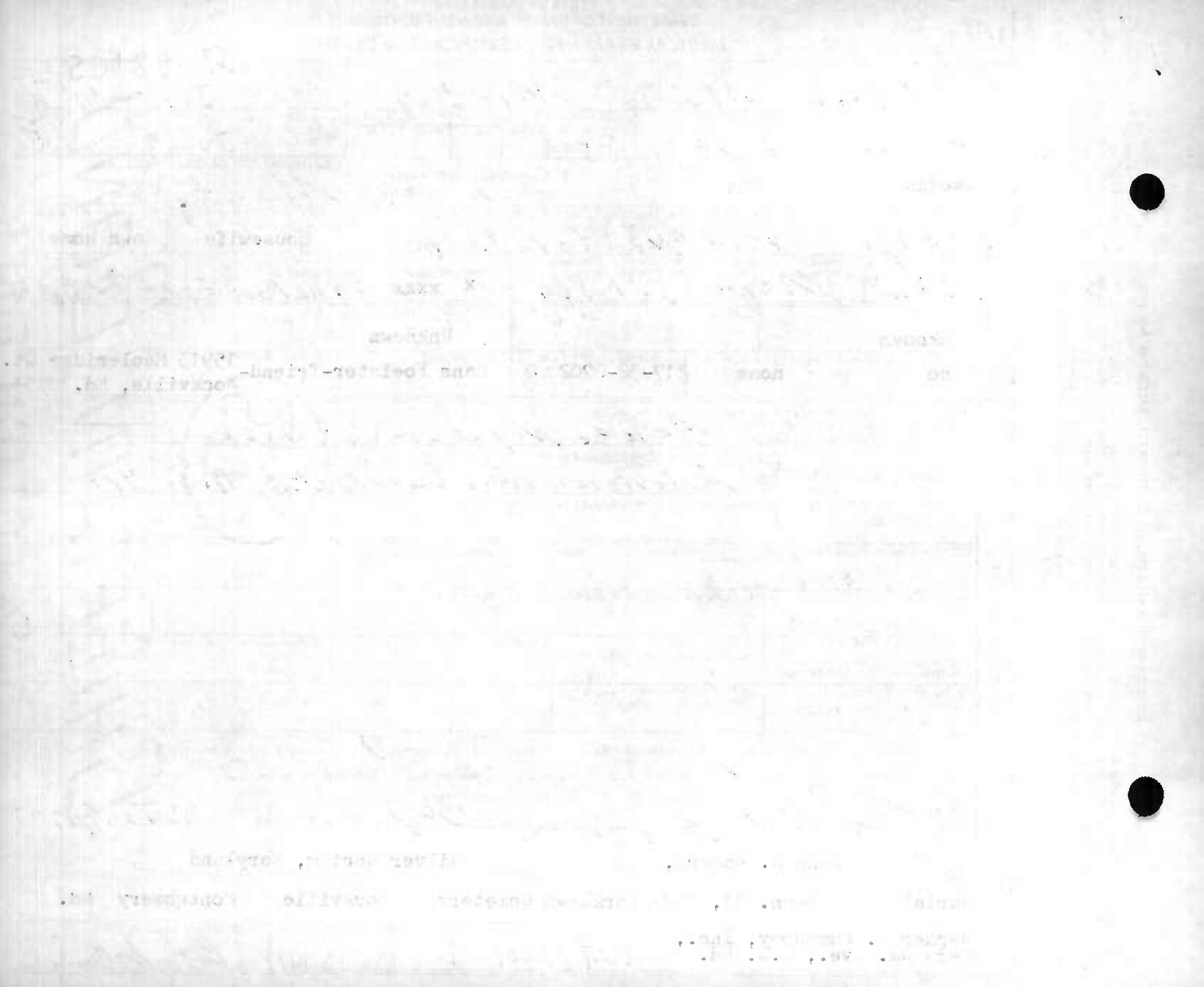
10-10-1964

10-10-1964



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 7-02195	
1. DECEASED NAME (TYPE OR PRINT) <i>Ellen Marie Midley</i>										2a. DATE KNOWN OF DEATH MONTH <i>12</i> DAY <i>9</i> YEAR <i>1977</i>										2b. HOUR OF DEATH <i>11:50</i> AM	
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH <i>6</i> DAY <i>29</i> YEAR <i>1911</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>65</i> YRS.		IF UNDER 1 YR. MONTHS <i>0</i> DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i> MIN. <i>0</i>		2c. DATE PRONOUNCED DEAD MONTH <i>12</i> DAY <i>9</i> YEAR <i>1977</i>		2d. HOUR OF DEATH <i>11:50</i> AM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Sweden</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.									
10. CITY OR TOWN OF DEATH <i>Ft. Spg.</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2714 Broad Ford Rd Apt 3</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>									
13a. STATE <i>MD</i>				13b. COUNTY <i>Mont</i>		13c. CITY OR TOWN <i>Ft. Spg.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>2714 Broad Ford Rd Apt 3</i>											
14. FATHER'S NAME FIRST <i>Unknown</i> MIDDLE <i></i> LAST <i></i>				15. MOTHER'S MAIDEN NAME FIRST <i>Unknown</i> MIDDLE <i></i> LAST <i></i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i> (IF YES, GIVE WAR) <i>none</i>													
16b. SOCIAL SECURITY NO. <i>217-32-0702-D</i>				17. INFORMANT NAME <i>Hans Foelster-friend</i> ADDRESS <i>15913 Mapleridge Ct. Rockville, Md. 20853</i>																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <i>1124</i> IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Arteriosclerotic Cardio Vas Dis. Yrs.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <i>None</i>																					
19a. DATE OF OPERATION <i>None</i>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>None</i>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <i>D.O.P.</i> M.D.				MEDICAL EXAMINER				DATE SIGNED <i>Jan 9, 1977</i>									
EXAMINER'S NAME (TYPE OR PRINT) <i>John S. Rogers, DME</i>				ADDRESS <i>Silver Spring, Maryland</i>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Jan. 11, 1977</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i>				23d. LOCATION <i>Rockville</i>		23e. COUNTY <i>Montgomery</i>		23f. STATE <i>Md.</i>							
24. FUNERAL DIRECTOR <i>Garner E. Pumphrey, Inc., 8434 Ga. Ave., S.S. Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>JAN 13 1977</i>				25b. REGISTRAR'S SIGNATURE <i>Pietro McCreedy</i>													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO. 77-02186

1. DECEASED NAME (TYPE OR PRINT) <b>MATTIE A. Mienley</b>			2a. DATE OF DEATH MONTH DAY YEAR HOUR <b>Jan 5 1977 6:30 AM</b>		
3 SEX <b>Female</b>	4 RACE <b>CAUCASIAN</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>JAN 21, 1889</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD		
10 CITY OR TOWN OF DEATH <b>KENSINGTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KENSINGTON GARDENS NURSING HOME</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b KIND OF BUSINESS OR INDUSTRY
13a STATE <b>MARYLAND</b>		13b COUNTY <b>MONTGOMERY</b>	13c CITY OR TOWN <b>TAKOMA PARK</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS <b>7051 CARROLL AVENUE</b>
14 FATHER'S NAME FIRST MIDDLE LAST <b>JOHN W. CHILCOTE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JOHANNA RICKABAUGH</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b SOCIAL SECURITY NO. <b>330-44-2711</b>	17 INFORMANT ADDRESS <b>DAUGHTER SILVER SPRING, MD. EDITH P. PETERSON, 10618 EDGEWOOD AVENUE</b>		
18 CAUSE OF DEATH Enter only one cause per line (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>485x</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>days.</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 16</b> , 19 <b>75</b> , to <b>Jan 5</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>12/2/76</b> , 19 <b>76</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A. W. Smith M.D.</b>		DEGREE		22c. DATE SIGNED <b>1/5/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. W. SMITH</b>		22e. ADDRESS <b>13018 GEORGIA AVE WHEATON, MD. 20906</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>1/7/77</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FT LINCOLN CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD PRI GEO MD.</b>	
24 FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1977</b>		
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										77-02197 REG. NO.			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Louis A Miller</b>										ESTIMATED <input checked="" type="checkbox"/> 1-19-77		5:40 P.M.	
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH (MONTH DAY YEAR) <b>2-19-22</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>XX</b>		2c. DATE PRONOUNCED DEAD <b>1-19-1977</b>		7a. HOUR <b>6:27 A.M.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Attorney, Pat. (Ret) Gov't.</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>D.S.</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>5506 Kirkwood Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry W. Miller</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Pemie Rogers</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. <b>WW11</b>		17. INFORMANT ADDRESS <b>Anne N. Miller, Wife, Same as item 13.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4124 Coronary Insufficiency Acute.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (c) stating the underlying cause last. (b) <b>Cardio Vascular Disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>John S. Ball</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER <b>John G. Ball, M.D.</b>				DATE SIGNED <b>Jan 19, 1977</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball, M.D.</b>				ADDRESS <b>9936 Old Georgetown Road, Beth., Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>1/21/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS, INC.</b>				ADDRESS <b>5130 WISCONSIN AVENUE, N. W.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>			

100-10107

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

Memorandum

TO : SAC, NEW YORK

FROM :

SAC, NEW YORK

SAC, NEW YORK

SAC, NEW YORK

SAC, NEW YORK

SUBJECT: [Illegible]

Very truly yours,  
[Illegible Signature]  
Special Agent in Charge



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				77-02198					
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				2b. HOUR		
Margaret G. Miller					11/20/77				8 <sup>30</sup> PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Caucasian		5-30-01		75 YRS		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Pa.		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda			Suburban Hospital			retired Sec.					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Montgomery			Bethesda			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e. STREET ADDRESS					
Milton D. Gehris			Margaret E. Kerlin			4949 Battery Lane #404					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17 INFORMANT					
NO			218-34-5019			509 Gordon Ave., Thomasville, Frank Richard Miller, M.D. Ga.					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 188X Cardiac Arrest										15 min	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Multiple Pulmonary Embolii										48 hrs	
(c) Adenocarcinoma of Urinary Bladder-Metastatic										5 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
Cardiac Arrhythmia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
11/17/77			Adenocarcinoma Urinary Bladder			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that (I) (the hospital) attended the deceased from 1/20/77 June 50 to 1/20/77 1977, that (I) (we) lost saw the deceased alive on 1/20/77 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED		
Frank Y. Jaggers Jr. MD			MD						11/21/77		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
FRANK Y. JAGGERS JR MD			6000 Executive Blvd, Rockville, Md								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Removal			1/22/1977			George Washington			Washington, D.C.		
24. FUNERAL DIRECTOR			25. DATE REC'D. BY REGISTRAR			26. REGISTRAR'S SIGNATURE					
Robert A. Pumphrey			JAN 24 1977			Bethesda, Maryland			Therapy McCready		

11-22-68

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

34

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 11-22-68 BY 1043 JAW/STW

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED  
DATE 11-22-68 BY 1043 JAW/STW



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 02199									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH			2b. HOUR		
Russell		S. Miller		Jan. 25th. 1977			5:30		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Mar 9-1897		79 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Penna.		U.S.A.				Montgomery			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Bel-Pre Health Center		Retired		Bel.Tel.Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD.		Montg.		Rockville				4608-Bel-Pre Rd.	
14. EATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last			
Clarence		W. Miller		Alice		Snyder			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		171-01-2467		Glen Miller (Son)		4608-Bel-Pre Rd. Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Prostate Gland.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>9/27</u> , 19 <u>76</u> , to <u>Jan 25</u> , 19 <u>77</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>January 22, 1977</u> , and that in (my) ( <u>our</u> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <u>we</u> ) ( <u>did</u> ) (did not) view the body after death.									
22b. SIGNATURE <u>Michael R. Dobridge M.D.</u> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>January 28 1977</u>		
22d. PHYSICIAN'S NAME (Type) <u>Michael R. Dobridge</u>					22e. ADDRESS <u>13975-Conn. Ave. Silver Spring, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		1/28/77		Conyngnam Union Cem.		Luzerne Co. Pa.			
24. FUNERAL DIRECTOR <u>Hines/Rinaldi F.H. Inc.</u> ADDRESS <u>11800-New Hamp. Ave. Silver Spring, Md.</u>					REG. REC'D BY REGISTRAR <u>Jan 31 1977</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. <b>77-02200</b>	
1- FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) <b>ROSE M. MOLDEN</b>						2a DATE OF DEATH MONTH DAY YEAR <b>JANUARY 6, 1977</b>			2b HOUR <b>12:35p</b>		
3 SEX <b>female</b>		4 RACE <b>caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>September 19, 99</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Naval Medical Center</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>			12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>Maryland</b> 13b COUNTY <b>Anne Arundel</b> 13c CITY OR TOWN <b>Annapolis</b>						13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>431 Burnside St.</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Lamb</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Wiggins</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>214 38 8789</b>		17 INFORMANT ADDRESS <b>Joan Riley, Rt 5, Box 11, Arnold, Md</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY <b>5699</b> IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Massive G. I. Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Acute renal failure</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that I (this hospital) attended the deceased from <b>January 5, 1977</b> to <b>January 6, 1977</b> , that I (we) lost above the deceased alive on <b>January 6, 1977</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death.)											
22b SIGNATURE <b>M. McCance LtMC USNR</b> DEGREE <b>ATTENDING PHYSICIAN</b> MEDICAL <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>Jan. 7, 1977</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>M. McCance, M. D.</b>						22e ADDRESS <b>National Naval Medical Center, Bethesda, Md.</b>					
23a BURIAL, CREMATION, REMOVAL <b>CREMATION</b>				23b. DATE <b>1/10/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>F. Lincoln</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD PG. MD.</b>			
24 FUNERAL DIRECTOR NAME <b>John M. Taylor &amp; Sons</b>				ADDRESS <b>Annapolis, Md.</b>		25a DATE REC'D. BY REGISTRAR <b>JAN 11 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCreedy</b>			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIA Caterina MONALDO					2a. DATE OF DEATH MONTH DAY YEAR Jan. 1. 77			2b. HOUR MIN. 6:48 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 3 04		6. AGE (IN YEARS LAST BIRTHDAY) XXIX 72 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) ITALY		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4507 FURMAN COURT		
14. FATHER'S NAME FIRST MIDDLE LAST CARMELO ULISSE					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERONICA DeFRANCESCO				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-10-1371NB		17. INFORMANT ADDRESS BIAGIO MONALDO SAME AS 13			HUSBAND		
18. CAUSE OF DEATH (Enter only one cause per line for (a) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary artery disease</u> (b) <u>Generalized arteriosclerosis</u> (c) <u>2 previous recent myocardial infarcts</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>2 previous recent myocardial infarcts</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>67</u> , to <u>1/1</u> , 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>12/15</u> , 19 <u>76</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Richard P. Deaney</u> DEGREE					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD P. DEANEY MD					22e. ADDRESS SILVER SPRING, MONTGOMERY MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/4/77		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING, MONTGOMERY MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS					25a. DATE REC'D BY REGISTRAR JAN 6 1977		25b. REGISTRAR'S SIGNATURE Dorothy McCready		
500 UNIVERSITY BLVD., W., SILVER SPRING, MD.									

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or reinterment.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		3 SEX				4 RACE			
Cleo Clea Lou Moore		FEMALE				Cauc.			
5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)				7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			
4-30-21		54-55 YRS				OKLAHOMA			
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				10 CITY OR TOWN OF DEATH			
		SILVER SPRING (MONTG.) MD.				TAKOMA PARK			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
WASHINGTON ADVENTIST HOSPITAL		HOMEMAKER				HOME			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MARYLAND		MONTGOMERY		ROCKVILLE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		724 CARR AVE.	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
BENJAMIN W. FAULKNER					TOMMIE MEEK				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					17 INFORMANT ADDRESS				
YES WWII					HOWARD W. MOORE (SAME AS ABOVE)				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Cardiovascular renal failure									3 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinomatosis									? weeks
DUE TO, OR AS A CONSEQUENCE OF (c) Suspected carcinoma of breast									? Months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
Dec 20, 1976		abdominal mass			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
		P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from Dec 30, 1976 to Jan 1, 1977, that (I) (last) saw the deceased alive on Dec 31, 1976, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE					DEGREE			22c. DATE SIGNED	
W.W. Eastman					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			Jan. 2, 1977	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
W.W. EASTMAN					831 University Blve., E., Silver Spring, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. STATE	
BURIAL		1-4-77		PARKLAWN MEM. PARK		ROCKVILLE		MD.	
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
ROBERT A. PUMPHREY					JAN 7 1977		History, K. Brady		

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATHREG. NO. **77-02203**1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Helen Anita D. Moore</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>6</b> YEAR <b>77</b>		2b. HOUR <b>12<sup>30</sup></b> P.M.
3 SEX <b>Female</b>	4 RACE <b>Negra</b>	5. DATE OF BIRTH MONTH <b>8</b> DAY <b>7</b> YEAR <b>1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Sakoma Park Co. Md.</b>	
10. CITY OR TOWN OF DEATH <b>Sakoma Park</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>	
13a. STREET ADDRESS <b>4023 Boarman ave</b>		13b. CITY OR TOWN <b>Bethesda</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>Robert De Neil</b>		15. MOTHER'S MAIDEN NAME <b>Annie Smith</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	
16b. SOCIAL SECURITY NO. <b>216-01-1952</b>		17. INFORMANT <b>Clarence D. Moore</b>		17b. ADDRESS <b>Same</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>582X CONGESTIVE HEART FAILURE</b> <b>RENAL FAILURE - UREMIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC GLOMERULO NEPHRITIS</b> <b>HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b> <b>3 1/2 YEARS</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 13, 1976</b> to <b>JAN 6, 1977</b> , that (I) (we) last saw the deceased alive on <b>JAN 6, 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert L. Krichmar</b>		DEGREE		22c. DATE SIGNED <b>JAN 7 1977</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT L. KRICHMAR MD</b>		22e. ADDRESS <b>7733 ALASKA AVENUE NW WASHINGTON DC 20012</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/14/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Natland Mem'l</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lanham Md.</b>		24. FUNERAL DIRECTOR NAME <b>William S. Skellie</b> ADDRESS <b>1727 M. Moore</b>			
25a. DATE REC'D. BY REGISTRAR <b>JAN 10 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Barbara B. Bandy</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 77-02204							
1. DECEASED NAME (TYPE OR PRINT) <b>Mitzi Muhlberg</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1-19-77</b>		2b. HOUR <b>10<sup>30</sup> P.M.</b>		
3 SEX <b>Female</b>		4 RACE <b>CAU</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 26 86</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>90</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Austria</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac Valley Nsg. Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9701 Fields Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Obermeyer</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>209 24 8088</b>		17. INFORMANT ADDRESS <b>Kurt Muhlberg, son same #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4123</b> IMMEDIATE CAUSE (a) <b>Congestive Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/18</b> , 19 <b>75</b> , to <b>1/19</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>1/19</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <b>M R Cascard</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>1/19/77</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MIGUEL R CASCARDO M.D.</b>				22e. ADDRESS <b>12400 BOBINK CT POTOMAC, Maryland 20854</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/21/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan</b>		23d. LOCATION <b>Alexandria, Virginia</b> STATE			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Wynson Wheeler Funeral Home 1331 Rockville Pike, Rockville, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1977</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

11-0350



*[Faint, illegible text and markings, possibly bleed-through from the reverse side of the page.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 77-02205									
1. DECEASED NAME (TYPE OR PRINT)		FIRST CORRIE		MIDDLE C.		LAST MUSE		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
								Jan. 31 1977		7 A M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White		July 4 1885		91 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
N.C.		U.S.A.				Montgomery MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Potomac		10824 Fox Hunt Lane				Homemaker		Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md.		Montgomery		Potomac				10824 Fox Hunt Lane			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
John K. Chambers				Martha E. Susong							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No				555-21-4152		Daughter Virginia L Merchant. Same as item 13.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma Lungs</i> (b) <i>Primary Carcinoma R. Breast</i> (c) <i>174X</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
										2 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Generalized Arteriosclerosis - 2 Chronic Nephritis</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>12/4/76</i> , 19 <i>76</i> , to <i>1/31</i> , 19 <i>77</i> , that (I) (we) last saw the deceased alive on <i>1/30</i> , 19 <i>77</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>John B. Marbury</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>1/31/77</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>John Bayne Marbury</i>						22e. ADDRESS <i>4545 Conn. Ave., N.W. Washington, D.C.</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2/2/1977</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Memorial Park</i>				23d. LOCATION CITY OR TOWN: <i>Rockville, Md.</i> COUNTY STATE			
24. FUNERAL DIRECTOR NAME <i>JOSEPH GAWLER'S SONS INC.</i> ADDRESS <i>2000 MUSEL AVE. N. W. WASH. D. C. 20036</i>						25a. DATE REC'D. BY REGISTRAR <i>FEB 3 1977</i>		25b. REGISTRAR'S SIGNATURE <i>Henry McCready</i>			

17-02202



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FOR #22c g504 2/24/77 gj  
1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02206

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>George A. Myers, Sr.</b>		2a DATE OF DEATH MONTH DAY YEAR <b>January 19, 1977</b>		2b HOUR <b>8:10</b> M	
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>May 27 97</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>79</b> YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10 CITY OR TOWN OF DEATH <b>Chevy Chase</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bethesda-Silver Spring N.H.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Draftsman</b>		12b KIND OF BUSINESS OR INDUSTRY <b>- -</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md</b> 13b COUNTY <b>Montg</b> 13c CITY OR TOWN <b>Chevy Chase</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <b>4400 East West Hgwy.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Charles M. E. Myers</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabelle Mellis</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WWI</b>		17 INFORMANT ADDRESS <b>Hellen F. Myers (Same as 13e)</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>TERMINAL PNEUMONIA</b> <b>1600</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARCINOMA</b> <b>7 NOS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CM. WITH</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAY</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PARKINSON'S DISEASE 10 YRS</b>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>Jan 19 77</b> to <b>JAN 19 77</b> , that (I) (we) lost saw the deceased alive on <b>2/18 19 77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>DR. LEO I. DONOVAN</b>		DEGREE		22c DATE SIGNED <b>1/24/77</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS <b>8215 WILSON AVE BETHESDA MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b DATE <b>1-22-77</b>		23c NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cem.</b>	
23d LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		24 FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Homes, P.A.</b>			
25a DATE REC'D. BY REGISTRAR <b>JAN 24 1977</b>		25b REGISTRAR'S SIGNATURE <b>Henry McCready</b>			

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.



(M)

77-02908

January 10, 1977

St. Louis, Mo.

Report

Info

Classification

1-7-77

1-7-77

Outgoing

Washington, D.C.

Henry James Helms-Silver Spring, Md. Washington

Mr. Helms - Gov. James M. 1400 West 1st Ave.

Charles M. Helms - 1400 West 1st Ave. St. Louis

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02207

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIE C. NALLEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-17-77</b>			2b. HOUR <b>6:03 P</b> M			
3. SEX <b>FEMALE</b>		4. RACE <b>CAU</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 15 91</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84 85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Wheaton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>RANDOLPH HILLS N. H.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk, Assoc. of</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroads</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry W. Day</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frances E. Carter</b>			13e. STREET ADDRESS <b>9204 Wendell Street</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>707-01-5757A</b>		17. INFORMANT ADDRESS <b>Marvin Nalley, see Item #13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Vascular Disease</b> <b>44409</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Smoking</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>76</b> , to <b>Jan 17</b> , 19 <b>77</b> , that (we) last saw the deceased alive on <b>Jan 17</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Bernard A. Fitzgerald M.D.</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-17-77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BERNARD A. FITZGERALD</b>					22e. ADDRESS <b>217 UNIVERSITY BLVD, SILVER SPRING MD</b>				
23a. BURIAL, CREMATION, REMOVAL (SEE INSTRUCTIONS) <b>Burial</b>			23b. DATE <b>1/21/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>		
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home, Inc.</b> ADDRESS <b>11800 New Hampshire Ave., Silver Spring, Md.</b>					25a. DATE RECEIVED BY REGISTRAR <b>JAN 24 1977</b> 25b. REGISTRAR'S SIGNATURE <b>History McCreedy</b>				

DHMH - 16 25M

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										77-02208 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)										FIRST MIDDLE LAST										2a. DATE KNOWN OF DEATH				2b. HOUR			
MYRTLE IONA NANSON																				1 17, 77				9:47 AM			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD				7d. HOUR										
F		W		10 2 07 69			YRS.		MONTHS		DAYS		1 17, 77				9:47 AM										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH															
SOUTH DAKOTA				U.S.A.								Montgomery MD.															
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Takoma Park				Washington Adventist Hospital								BINDER WORKER															
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS?										13b. STREET ADDRESS							
13a. STATE										13b. COUNTY										13c. CITY OR TOWN							
MD										Prince George's										Adelphi							
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST										FIRST MIDDLE LAST																	
IVOR										JOHNSON										MARTHA ANDERSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT								ADDRESS											
No				212 20 1963A				ROBERT H. NANSON (SAME AS 13c.)																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I DEATH WAS CAUSED BY:																											
428X IMMEDIATE CAUSE (a) Acute Myocardial Dis.																											
DUE TO, OR AS A CONSEQUENCE OF																											
Chronic Myocardial Dis.																											
(b) DUE TO, OR AS A CONSEQUENCE OF																											
(c)																											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																											
None																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY?									
None																		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
				HOUR A.M. MONTH DAY YEAR																							
				P.M. 19																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION																			
								STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																											
ACTUAL SIGNATURE																		TITLE (SPECIFY)		MEDICAL EXAMINER				DATE SIGNED			
EXAMINER'S NAME (TYPE OR PRINT)																		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION															
Burial				Jan. 20, 1977				For Lincoln Cemetery				Baltimore															
24. FUNERAL DIRECTOR																		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
NAME ADDRESS																		JAN 20 1977		Henry McCready							
Takoma Funeral Home, 254 Carroll St., N.E.																											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC. NO. 118-89208
1. DECEASED NAME (TYPE OR PRINT) <b>WILBUR Fiske Nash, III</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>1-1-1977</b>			2b. HOUR <b>11:53 AM</b>				
3. SEX <b>Male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 2, 1924</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>52 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>Jan. 1 1977</b>		2d. HOUR <b>12:00 PM</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Brookeville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>21110 Georgia Avenue</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Air Line</b>		
13a. STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Montgomery</b>	13c. CITY OR TOWN <b>Brookeville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>21110 Georgia Avenue</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Wilbur Fiske Nash Jr.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice - Smith</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>WW II 218-12-2206</b>		17. INFORMANT ADDRESS <b>Mrs. W. F. Nash 111 Same as # 13</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun shot wound of head -</b> <b>955X</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Self Inflicted</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11:55 PM 1-1-1977</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Shot self with shot gun.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>21110 Georgia Ave. Brookeville Montgomery Md</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE <b>John G. Ball</b>			TITLE (SPECIFY) M.D. <b>Deputy</b> MEDICAL EXAMINER			DATE SIGNED <b>Jan. 1, 1977</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN G. BALL</b>			ADDRESS <b>BETHESDA, MD-2</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 4, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Sunshine Mont. Maryland</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis H. Barber Laytonville, Md. 20760</b>					25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Harvey McCreedy</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH				REG. NO. 77-02210			
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. HOUR	
SAMUEL						NELSON		January 28, 1977 1:00 P.M.	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		July 1, 1898		78 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Russia		USA				Montgomery MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Chevy Chase		Bethesda-Silver Spring Center		Manufacturer		Clothing			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS	
New York		-----		Brooklyn		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		35 Sea Coast Terrace	
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT	
(unknown)		(unknown)		unknown		112-09-2675		5225 Pooks Hill Rd Dr. Morton Nelson Bethesda, Md.	
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>	
4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>ARTERIOSCLEROTIC Heart disease</u> (c) <u>METASTATIC Cancer Prostate</u>								YEARS 2 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>AMYOTROPHIC lateral Sclerosis</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 5/4 19 76, to 1/28 19 77, that (b) we last saw the deceased alive on 1/26 19 77, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (If not, I did not see the body after death)									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
<u>M. Shapiro</u>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				1-28-77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Morton W. Shapiro, M.D.				5225 Pooks Hill Road, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1-30-77		New Montefiore		Pinelawn, New York			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Danzansky-Goldberg		1170 Rockville Pike		FEB 2 1977		<u>Anthony McCready</u>			

BP

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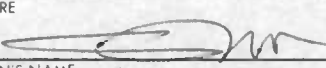
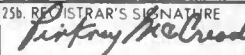


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 77-02211					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITH — NEWCOMB				2a DATE OF DEATH MONTH DAY YEAR 1-28-77				2b HOUR / 5 4 P.M.					
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 2-23-89		6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD							
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COLLINGSWOOD Nsg. Ctr.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Home					
13a STATE VIRGINIA				13b COUNTY		13c CITY OR TOWN ARLINGTON		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET ADDRESS 955 S. Columbus St	
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Wright				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Norma Cox									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17 INFORMANT Nellie Droegemeyer (dau)		ADDRESS 955 S. Columbus St Arlington, Va.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombotic cerebral thrombosis</u> 4339 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>year</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a I certify that (I) (this hospital) attended the deceased from <u>7/23/75</u> , 19____, to <u>1/28/77</u> , 19____, that (I) (we) lost saw the deceased alive on <u>1/19/77</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE 				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/28/77					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSOOTH LEKAKOUL MD				22e. ADDRESS 8218 Wisconsin Ave, Bethesda Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 2/1/77		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Md.					
24. FUNERAL DIRECTOR NAME Ives Funeral Home				ADDRESS 2847 Wilson Blvd Arl, Va.				25a. DATE REC'D. BY REGISTRAR FEB 2 1977		25b. REGISTRAR'S SIGNATURE 			

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OFFICE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE FILES AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 77-02212	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH	
WILLIAM G NORCROSS				MONTH DAY YEAR 77 11 19 76 8:45 p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.
MALE	WHITE	AUG. 26, 1898	78 RS.	MONTHS DAYS	HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		2c. DATE PRONOUNCED DEAD	
VIRGINIA		U.S.A.		MONTH DAY YEAR 77 11 19 76 8:45 p.m.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Takoma Park		Washington Adventist Hospital		Montgomery County MD.	
12a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. KIND OF BUSINESS OR INDUSTRY		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Maryland		Montgomery		Ret. Bus Driver	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Maryland		Montgomery		Takoma Park	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. INSIDE CITY LIMITS?	
John Norcross		Naomi Jones		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
No		230 09 0780		McGuire V. Norcross Same as #13 (Wife)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Chronic Heart Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Yrs.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
<u>John R. Rogers</u>		M.D. <u>Doc</u>		77 11 19 76	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		MONTGOMERY COUNTY, MARYLAND	
John R. Rogers					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		1/14/77		Et. Lincoln Cemetery	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Francis Gasch's Sons Funeral Home, P.A.		JAN 17 1977		<u>Henry McCreedy</u>	
Hyattsville, Maryland					

17-02343

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHM-17 20M 1/73  
(VR A15 ME (5))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02213	
1. DECEASED NAME (TYPE OR PRINT) <b>ELIZABETH LOWE NYIRI</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>Jan 21 1977</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>9</b> DAY <b>13</b> YEAR <b>50</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>25</b> YRS.		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>		7b. HOUR <b>4:10</b> M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>		MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Librarian</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>			
13a. STATE <b>MD</b>		13b. COUNTY <b>Mont</b>		13c. CITY OR TOWN <b>Olney</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>12704 Coast BRIDGE PL</b>			
14. FATHER'S NAME FIRST <b>Robert</b> MIDDLE <b>W.</b> LAST <b>Low</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Herrilyn</b> MIDDLE <b>-</b> LAST <b>Ramsay</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>045-40-5593</b>		17. INFORMANT <b>Jack P. Nyiri</b>		ADDRESS <b>Same as # 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkins Dis.</b> 201X Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>		EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) <b>M.D. Dep. Silver Spring, Maryland</b>		DATE SIGNED <b>Jan 24 1977</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>1-22-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee Funeral Home</b>		23d. LOCATION CITY OR TOWN <b>Washington, D. C.</b>		COUNTY <b>D. C.</b>		STATE	
24. FUNERAL DIRECTOR NAME <b>Francis H. Barber</b> ADDRESS <b>Laytonsville, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Linton McQuinn</b>			

Images of the world

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02214  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	1. 12 77			9:15 A.M.
2. VALERIAN - DOBOLENSKY								
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE	WHITE	MONTH DAY YEAR	51	MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
FRANCE	U.S.A.		MDA T GOMERY MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring	HOLY CROSS HOSPITAL							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	13b. STATE	13c. COUNTY	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
13a. MD.	13b. MONT	13c. CHEVYCHASE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	8405 FARRELL DRIVE				
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST	FIRST MIDDLE LAST							
14. ALEXANDER DOBOLENSKY	15. OLGA BOUTURLINE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS				
16a. NO	16b. 441	WIFE - LUDMILA DOBOLENSKY		SAME AS #10				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
5309 IMMEDIATE CAUSE (a) Hypertension & Lock							12 hours	
DUE TO, OR AS A CONSEQUENCE OF (b) Asystole & fatal bleeding							7 days	
DUE TO, OR AS A CONSEQUENCE OF (c) Esophageal tear							2 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
Sepsis with peritonitis, cirrhosis of liver								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
		P.M. 19						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 9, 19 77, to Jan 12, 19 77, that (I) (we) last saw the deceased alive on Jan 12, 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE		22c. DATE SIGNED				
Rough Landman M.D.		M.D.		1/12/77				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS						
Rough Landman M.D.		1106 Spring St. Silver Spring Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial	1-14-77	ROCK CREEK CEM.		WASHINGTON, D.C.				
24. FUNERAL DIRECTOR NAME		25. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
James E. DeVol		JAN 24 1977		Rough Landman				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



41393-87

(A)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02215

1. DECEASED-NAME (Type or print) <b>MARY ANDERSON OGDEN</b>			2a. DATE OF DEATH Month <b>1</b> Day <b>1</b> Year <b>77</b>		2b. HOUR <b>1245</b> M
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>2/20/86</b>		6. AGE (In years last birthday) <b>90</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>N.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>MONTGOMERY</b> Md.		
10. CITY OR TOWN OF DEATH <b>CHEVY CHASE</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>4000 Rosemary St</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>DC</b>	13b. COUNTY <b>WASHINGTON</b>	13c. CITY OR TOWN <b>WASHINGTON</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>3040 Idaho Ave NW</b>	
14. FATHER'S NAME First <b>ISAAC</b> Middle <b>ANDERSON</b> Last <b>ANDERSON</b>	15. MOTHER'S MAIDEN NAME First <b>EMMA</b> Middle <b>LARINA</b> Last <b>McGOWAN</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO. <b>577641503</b>	17. INFORMANT <b>Mrs. Mary Ogden Thompson</b> <b>4000 Rosemary St., Chevy Chase, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHOLAGIO CARCINOMA</b> <b>1551</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION <b>11/18/76</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>SMAO</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1960</b> , to <b>1/1</b> , <b>1977</b> , that (I) (we) last saw the deceased alive on <b>1/1</b> , <b>1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>HD Ecker MD</b>	DEGREE <b>MD</b>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>1/1/77</b>		
22d. PHYSICIAN'S NAME (Type) <b>Henry D. Ecker MD</b>	22e. ADDRESS <b>916-19th St. N.W. DC 20006</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE <b>1/2/77</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Alexandria, Virginia</b>		
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Homes, P.A.</b>		25a. REC'D BY REGISTRAR <b>JAN 5 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry D. Ecker</b>	
25c. ADDRESS <b>7557 Wisconsin Ave., Bethesda, Md.</b>					

MEDICAL CERTIFICATION

100% COTTON LINE

4/1/50

TRIM

WOMEN

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02216

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR FIRST MIDDLE LAST) HYMAN A. OLESKER			2a DATE OF DEATH MONTH DAY YEAR 1-26-77			2b HOUR 6:20 P.M.					
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 2 12 14		6 AGE (IN YEARS LAST BIRTHDAY) 62 YRS		7 UNDER 1 YEAR MONTHS DAYS 11		7 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Administrator			12b KIND OF BUSINESS OR INDUSTRY U.S. Gov't		
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Md				13c CITY OR TOWN Silver Spring		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 2310 East West H'way			
14 FATHER'S NAME FIRST MIDDLE LAST NATHAN NMI Olesker				15 MOTHER'S MAIDEN NAME FIRST LAST Anna Krongold							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW 2				16b SOCIAL SECURITY NO. 218-30-8059		17 INFORMANT ADDRESS Charlotte Olesker (Same as # 13)					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> 2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aneurysm f. mellitus</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HRS 10 YRS.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Aneurysm f. mellitus</u>											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>April 15</u> , 19 <u>1960</u> , to <u>1/26</u> , 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>1/12</u> , 19 <u>77</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) did not view the body after death.											
22b SIGNATURE <u>Max G. Sherer MD</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c DATE SIGNED 1/26/77		
22d PHYSICIAN'S NAME (TYPE OR PRINT) MAX G. SHERER MD						22e ADDRESS 800 Pershing Dr. Silver Spring, Md 2090					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b DATE 1/27/77			23c NAME OF CEMETERY OR CREMATORY KING DAVID MEM. GARDEN			23d LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA		
24 FUNERAL DIRECTOR NAME D.M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.						25a DATE REC'D. BY REGISTRAR JAN 31 1977			25b REGISTRAR'S SIGNATURE Petry McCreedy		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical officer must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				77-02217 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 01 18 77			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Garnett Payne				2b. HOUR 9:10 p.m.			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 04 12 00		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Md.		13b. COUNTY Monta.		13c. CITY OR TOWN Dickerson		13e. STREET ADDRESS 19220 Peachtree Road	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Payne				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Henry Payne 2514 Olson Street Marlow Heights, Maryland 20031			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> 4369							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48h
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerosis</i>							YRS
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/1/76, 19, to 1/16/77, 19, that (I) (we) last saw the deceased alive on 1/18/77, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Robert Millman, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/19/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Millman, MD				22e. ADDRESS 15500 Park Dr Gaithersburg, MD 20860			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-22-77		23c. NAME OF CEMETERY OR CREMATORY Elijah Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Poolesville, Monta, Md.	
24. GENERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Washington St. Pockville, Md. 20850		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 24 1977 Anthony McCreedy	

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FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02218

1. DECEASED NAME (TYPE OR PRINT) <b>WALTER E. PAYNE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>JANUARY 01 1977</b>		2b. HOUR <b>0750am</b>
3. SEX <b>Male</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>October 05 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KENTUCKY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NATIONAL NAVAL MEDICAL CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>ST. Marys</b>	13c. CITY OR TOWN <b>Scotland</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas NMN PAYNE</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ellen NMN McBIRNEY</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input checked="" type="checkbox"/> YES		16b. SOCIAL SECURITY NO. <b>27 years 560 50 9789</b>		17. INFORMANT <b>Scotland Beach 20689</b> <b>Evangelina Payne Scotland, md. 20600</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED AORTIC ANEURYSM</b> <b>4412</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION <b>01 JAN 1977</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abdominal Aortic Aneurysm</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>31 December 1976</b> to <b>01 January 1977</b> , that (I) (we) last saw the deceased alive on <b>01 January 1977</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John H. Shelby, M.D.</b>				22c. DATE SIGNED <b>1 Jan. 1977</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN H. SHELBY LCDR MC USNR</b>				22e. ADDRESS <b>NATIONAL NAVAL MEDICAL CENTER, BETHESDA</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-5-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	
24. FUNERAL DIRECTOR NAME <b>ROBINSON FUNERAL HOME LEONARDTOWN, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robt. McCready</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If a delay be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or once.

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02219  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MICHELE PETRUZZELLI</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>8 1-12-77 8 98</b>		2b. HOUR <b>6:35 P.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 3 95</b>	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY & TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co.</b>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>MD</b>		13a. COUNTY <b>Mont</b>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ANGELO PETRUZZELLI</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANNA MARIA CAMPANARO</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	
16b. SOCIAL SECURITY NO. <b>578-10-7772</b>		17. INFORMANT NAME ADDRESS <b>PAULINE PETRUZZELLI SAME AS 13 WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>D.C. TRANSIT</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 4319 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 <b>73</b> , to <b>1-12</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1-11</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Robert Kramer MD</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/12/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT KRAMER</b>		22e. ADDRESS <b>8630 FENTON ST - SIL SPR.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/15/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>			
25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>			

MEDICAL CERTIFICATION

(M)

Closed to medical examiners

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH THE BUREAU AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. 022220	
1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE GRAFTON LAST PLATT						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12-26, 1976		2b. HOUR A M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY FEB. 23 1901		6. AGE (IN YEARS) LAST BIRTHDAY 75 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan. 3 1977	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD			
10. CITY OR TOWN OF DEATH Cherry Chase				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7103 Beech Wood Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 7103 Beech Wood Dr.			
13a. STATE Md.						13b. COUNTY Montgomery		13c. CITY OR TOWN Cherry Chase			
14. FATHER'S NAME FIRST MIDDLE LAST Guy Wakeman Steele						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Pomeroy Rogers					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Son. ADDRESS 96734 Grafton S. Platt. 629 Milokai, Kailua, Hawaii					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> 1194H Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER DATE SIGNED Jan. 3, 1977			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS 7936 Old Georgetown Rd., Beth. Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/10/1977		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.	
24. FUNERAL DIRECTOR NAME JOSEPH GAMMEL'S SONS, INC. ADDRESS 5130 WISCONSIN AVENUE, N. W.						25a. DATE REG'D. BY REGISTRAR JAN 18 1977					
25b. REGISTRAR'S SIGNATURE P. J. McCready											

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## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02221

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>VIERA POGOZELSKIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-17-77</b>		2b. HOUR <b>9:30 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 28 89</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FAIRLAND NURSING Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. COUNTY OF DEATH <b>Montgomery</b>		13b. CITY OR TOWN <b>Silver Spring</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>25 E. Wayne Avenue,</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alexander Von Budde</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Barbara Tuleninova</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>477-34-5284-D</b>		17. INFORMANT ADDRESS (same as 13e) <b>Irene Suboczewski-daughter-</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiovascular accident</b> <b>4123</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 1976</b> to <b>Jan 27 1977</b> , that (I) (we) first saw the deceased alive on <b>1/17 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Thos G Ward Jr</b>				DEGREE <b>MD</b>		22c. DATE SIGNED 1977 <b>Jan. 27, 1977</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos. G. WARD,</b>				22e. ADDRESS <b>6116 Robinwood Rd, Bethesda, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Feb. 1, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montgomery Md</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>E. Pumphrey, Inc., Clark E. Wisor 8434 Ga. Ave., S.S. Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 31 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1888-89

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

Report of the  
Director of the  
Bureau of Plant Industry  
for the year 1888-89  
by  
C. D. C. ...  
and  
J. H. ...

XX

XX

Printed by the Government Printing Office  
Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02222  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
George C. Poppo		1/28/77		5:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
MALE	CAUCASIAN	MAY 10, 1898	78 YRS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
GREECE	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
CHEVY CHASE	7723 ROCTON AVE.	STRUCTURAL ENG.		ENGINEERING	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD.	MONTG.	CHEVY CHASE	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	7723 ROCTON AVE.	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.			
CONSTANTINE - PAPADOPOULOS	STAMATINA	209-09-3805			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
NO	209-09-3805	GEORGIA V. POPPS, SAME AS #13.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>arteriosclerotic hypertension</u>					
4121 DUE TO, OR AS A CONSEQUENCE OF					9 1/2 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>heart disease</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR				
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION	CITY OR TOWN COUNTY STATE		
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22a. I certify that (1) (this hospital) attended the deceased from 1/6/77, 19, to 1/28/77, 19, that (1) (we) lost					
saw the deceased alive on 1/27/77, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
Bernard J. Walsh M.D.			1/28/77		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
Bernard J. Walsh	1800 Eye St. N.W. D.C.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
BURIAL	JAN. 31, 1977	PAKELAWN Cem.	ROCKVILLE, MD.		
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
JOSEPH GAWLER'S SONS	FEB 2 1977		History McCreedy		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		77-02223 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Raymond E Porter</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 19 1977</b>		2b. HOUR <b>1:25</b> AM	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MCH 3, 1933</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>43</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Va.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hosp</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YEARS) <b>Dept. Sheriff</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>542 Calvin Lane</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clyde Porter</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Hall</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korean 296 28 5279</b>		17. INFORMANT ADDRESS <b>Nancy L. Porter, wife, same #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY <b>1579 Metastatic Adenocarcinoma</b> IMMEDIATE CAUSE (a) <b>7 Pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>7 Pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>7 Pancreas</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> , 19 <b>76</b> , to <b>1/18</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1/18</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stephen Newman</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/19/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>STEPHEN NEWMAN, M.D.</b>		22e. ADDRESS <b>5411 West Cedar Lane, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE <b>1-21-77</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b>		25a. DATE RECEIVED BY REGISTRAR <b>JAN 24 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robert McCreedy</b>	
24. FUNERAL DIRECTOR ADDRESS <b>1331 Rockville Pike, Rockville, Md.</b>					

MEDICAL CERTIFICATION

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02224 REG. NO.	
1. FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST TILLIE XXX POTASH				2a. DATE OF DEATH MONTH DAY YEAR TUES. 1 25 77				2b. HOUR 9 40 AM	
3 SEX FEMALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 9 1 1893		6 AGE (IN YEARS LAST BIRTHDAY) 83		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.					
10 CITY OR TOWN OF DEATH SILVER SPRING,		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN U.S. CITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK OR TOY OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY AT HOME			
13a. STATE MARYLAND 13b. COUNTY MONTGOMERY 13c. CITY OR TOWN SILVER SPRING											
14 FATHER'S NAME FIRST MIDDLE LAST PAUL BULMASK		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA MILLER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2108 COLERIDGE DR. #20910					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 579-30-8312		17. INFORMANT JOSEPH POTASH		ADDRESS MD. 20901 901 MALTA LA., SILVER SPRING					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Thrombosis of Superior &amp; Inferior Mesenteric Arteries</u> 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours _____ Years _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>											
19a. DATE OF OPERATION 1-25-77		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Acute Surgical Abdomen</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>approximately</u> , 19 <u>65</u> , to <u>January 25</u> , 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>Jan. 25</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Gene U. Cohen</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>Jan. 26, 1977</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GENE U. COHEN				22e. ADDRESS 10301 GEORGIA AVE, SILVER SPRING MD 20902							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-27-77		23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN				23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.			
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD., BALTO., MD 21215				25. DATE REC'D. BY REGISTRAR FEB 1 1977		25. REGISTRAR'S SIGNATURE <u>Anthony McCreedy</u>					

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 77-02225  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Harry Lee Powell</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 27 77</b>			2b. HOUR <b>7:20</b> P.M.				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Apr. 11 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Interior Decorator U.S. Gov.</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS <b>4511 Chestnut St.</b>										
14. FATHER'S NAME FIRST MIDDLE LAST <b>Max Preston Powell</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Edna Winifred</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>579-03-4658</b>		17. INFORMANT ADDRESS <b>Rockville Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4339 Respiratory Failure + Emphysema</b>			DUE TO, OR AS A CONSEQUENCE OF - (b) <b>Cerebral Thrombosis</b>			DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe Arterio Sclerosis</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <b>W</b> (the hospital) attended the deceased from <b>Jan 27</b> , 19 <b>77</b> , to <b>date</b> , 19 <b>77</b> , that (I) <b>(was)</b> lost <b>and</b> the deceased <b>was</b> on <b>Jan 27</b> , 19 <b>77</b> , and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> (did) <b>(do not)</b> view the body after death.										
22b. SIGNATURE <b>John S Ball</b>			DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>Jan 28, 1977</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>Jan 30, 77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery Suitland Md</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>DeVol Funeral Home John DeVol</b>			ADDRESS <b>Wash DC 222</b>		25a. DATE RECD. BY REG. CLERK <b>FEB 5 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Barry McCreedy</b>			

5000 BP

25-20-11

(11)

*[Faint, illegible handwriting on lined paper]*



1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

77-02226

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE EDNA POWERS			2a. DATE OF DEATH MONTH DAY YEAR Jan. 16 1977			2b. HOUR 7 AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 17 1890		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Herman Wilson Health Care Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY RETIRED	
13a. STATE MD.			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		
14. FATHER'S NAME FIRST MIDDLE LAST James H. Love			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally Mc Knight		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 527-28-2786-A		17. INFORMANT PTs. Identification Record - Wilson Health Care Center		
13e. STREET ADDRESS 201 Russell Avenue							

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) \_\_\_\_\_

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Cerebrovascular Disease

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-9, 1974, to 12-16, 1977, that (we) have saw the deceased alive on 1-11-77, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE W. H. Killay M.D. for Thomas Ward M.D.		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 16 Jan 77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W.H. Killay M.D.		22e. ADDRESS Thomas Ward M.D. 8218 Wisconsin Ave Bethesda					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Jan 18, 1977		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL.		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VA.	
24. FUNERAL DIRECTOR NAME TYSON WHEELER F.H. ROCKVILLE MD.		25a. DATE REC'D. BY REGISTRAR JAN 20 1977		25b. REGISTRAR'S SIGNATURE Pietro McCreary			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

11-05556

UNITED STATES DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

TO: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

DATE: [illegible]

BY: [illegible]

FOR: [illegible]

RE: [illegible]

ATTN: [illegible]

THRU: [illegible]

INFO: [illegible]

NOTE: [illegible]

REFERENCE: [illegible]

ENCLOSURE: [illegible]

REMARKS: [illegible]

SIGNATURE: [illegible]

TITLE: [illegible]

DEPARTMENT: [illegible]

OFFICE: [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02227  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James Cecil Pryor			2a. DATE OF DEATH MONTH DAY YEAR January 9, 1977		2b. HOUR 3:30P M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR July 1, 1920	6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama	7b. CITIZEN OF WHAT COUNTRY? UAS	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10 CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Clinical Center, NIH Beth.Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman	12b. KIND OF BUSINESS OR INDUSTRY U.S.Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY P.G.	13c. CITY OR TOWN Brandywine	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Rt. #1 Box 148	
14 FATHER'S NAME FIRST MIDDLE LAST R. N. Richard F. Pryor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace - Hamby (dec)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17 INFORMANT Medical Record Dept. Clinical Center, NIH Bethesda, Md. 20014		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: 1621 IMMEDIATE CAUSE (a) Oat Cell Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 15, 1976, to January 9, 1977, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on January 9, 1977, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.					
22b. SIGNATURE Joseph F. O'Donnell MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/10/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH F. O'DONNELL MD		22e. ADDRESS National Institutes Of Health Clinical Center, Bethesda, Maryland 20014			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 1-13-77	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Virginia	
24 FUNERAL DIRECTOR NAME Huntt Funeral Home Waldorf, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 17 1977		25b. REGISTRAR'S SIGNATURE Jeffrey M. Brady	

1880. 8. 7. 1880. 8. 7.

DIESEL/CLK

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
15M 7/76



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 02228

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
DECEASED NAME (TYPE OR PRINT)		DATE ESTIMATED		HOUR	
ERIKA MARIA QUISH		1-19-1977		M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
female	white	9 5 32	44 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH	
Germany	Germany	WIDOWED	DIVORCED	Montgomery County MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda	Suburban Hospital	Homemaker			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Montgomery	Rockville	YES <input type="checkbox"/> NO <input type="checkbox"/>	894 College Parkway	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	17. INFORMANT			
FIRST MIDDLE LAST	FIRST MIDDLE LAST	ADDRESS			
	Sauer	894 College Pkwy Rockville, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT			
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		Frank J. Quish			
No					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Acute subdural hematoma					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
von Willebrand's Disease					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?			
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
	xx 1-18-1977	Bumped head on picture frame.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION			
	home	894 College Pkwy. Rockville Montgomery Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Ann M. Dixon, M.D.		Assistant		1-20-77	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			
Ann M. Dixon, M.D.		111 Penn St.			
23a. BURIAL, CREMATION, REMOVAL	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION		
Burial	1/24/77	Fairfax Memorial Park	Fairfax, Virginia		
24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Everly Funeral Home	JAN 26 1977	Anthony McCready			

05530-55

(M)



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02229

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Renee Dianne RALPH			2a. DATE OF DEATH MONTH DAY YEAR January 20, 1977		2b. HOUR 1235A M
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 26 1963	6. AGE (IN YEARS LAST BIRTHDAY) 13 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student	12b. KIND OF BUSINESS OR INDUSTRY School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Arkansas	13b. COUNTY Mississippi	13c. CITY OR TOWN Osceola	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 116 South Elm St.	
14. FATHER'S NAME FIRST MIDDLE LAST Steve Ralph, Jr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Moore			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A	17. INFORMANT ADDRESS Capt. Steve Ralph USN See item 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thromboembolus 2262 DUE TO, OR AS A CONSEQUENCE OF (b) Craniotomy for removal of craniopharyngioma Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I (this hospital) attended the deceased from Dec. 28, 1976, to Jan. 20, 1977, that I (we) lost saw the deceased alive on Jan. 20, 1977, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I (we) did) (did not) view the body after death.					
22b. SIGNATURE  L. H. FINK, M.D.				22c. DATE SIGNED Jan. 21, 1977	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. H. FINK, M.D.				22e. ADDRESS National Naval Medical Center, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 24, 1977		23c. NAME OF CEMETERY OR CREMATORY Arlington National	
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.		23e. DATE REC'D. BY REGISTRAR JAN 26 1977			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home, Bethesda, Md.		25b. REGISTRAR'S SIGNATURE 			

83380-53

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR 115 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 77-02230

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE KNOWN OF DEATH		2c. DATE PRONOUNCED DEAD		2d. DATE KNOWN OF DEATH		2e. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		MONTH		DAY	
William		P.		Reuss				1-3		1977	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.	
Male		Cauc		Jan 21, 1890		86 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	
Penna		U S A		WIDOWED		Montgomery County MD.		Bethesda		Suburban Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Electrician Ret		U S Gov't		Md		Montgomery		Silver Springs		YES	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS	
Louis Reuss		Margaret Brown		Yes		578 20 7393		Elizabeth Mulcahey		Silver Springs, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. IMMEDIATE CAUSE (a)		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		21. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		22. DATE OF OPERATION		23. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
PART 1 DEATH WAS CAUSED BY:		Coronary Insufficiency Acute				Fracture Left Hip - Diabetes Mellitus		Dec 31, 1976		Repair of fracture of hip	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b) Cardiovascular Disease									
		(c) Generalized Arterio Sclerosis									
24. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		25. TIME OF INJURY		26. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		27. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		28. LOCATION		29. CITY OR TOWN	
21a. INJURY OCCURRED WHILE AT WORK		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY	
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21a. INJURY OCCURRED WHILE AT WORK		21b. PLACE									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02231

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM E RICHARDS, SR.		2a. DATE OF DEATH MONTH DAY YEAR 1 27 77		2b. HOUR 12:15 P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 6 - 1898	
6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. BIRTHPLACE (STATE OR FOREIGN) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Post Mgr. U.S.P.	
11. CITY OR TOWN OF DEATH Rockville		12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wildwood Health Center		13. KIND OF BUSINESS OR INDUSTRY	
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Montgomery 13c. CITY OR TOWN Silver Spring		15. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		16. STREET ADDRESS 10211 Pierce Dr. Bt. Md.	
17. FATHER'S NAME FIRST MIDDLE LAST Richards		18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] No	
20. SOCIAL SECURITY NO.		21. INFORMANT Chas. L. Richards (Jr.)		22. ADDRESS 800 - Barry Mills Ave - Bt. Md.	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4339 Terminal Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
27. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		28. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		29. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
30. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		31. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		32. LOCATION STREET CITY OR TOWN COUNTY STATE	
33. I certify that (I) (this hospital) attended the deceased from 4/10/75, 19 to 4/27/77, 19, that (I) (we) lost saw the deceased alive on 4/27/77, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
34. SIGNATURE		35. DEGREE		36. DATE SIGNED 1/27/77	
37. PHYSICIAN'S NAME (TYPE OR PRINT) OSOTH LEKIBULI, M.D.		38. ADDRESS 8118 Wisconsin Ave Bethesda Md		39. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		41. DATE Jan 29 - 77		42. NAME OF CEMETERY OR CREMATORY Beechmont Cemetery	
43. LOCATION CITY OR TOWN Crown Pk. Bt. Md.		44. COUNTY Bt. Md.		45. STATE Md.	
46. FUNERAL DIRECTOR Thomas F. Hulse		47. ADDRESS 254 Carroll St. NW. 20012		48. DATE REC'D. BY REGISTRAR FEB 2 1977	
49. REGISTRAR'S SIGNATURE Anthony McCready					

10550-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02232

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Alta Louise RIGGS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan 30 1977</b>		2b. HOUR <b>12:38 AM</b>
3. SEX <b>Female</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MAR. 10 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>14619 Good Hope Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md. Montg. Silver Spring</b>			13b. COUNTY <b>Montg.</b>		
13c. CITY OR TOWN <b>Silver Spring</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>14619 Good Hope Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Thomas</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Young</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
17. INFORMANT ADDRESS <b>Bradley Riggs (husband) same as #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4339 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cerebral Thrombosis</b>					1 month.
(c) <b>Arteriosclerosis</b>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Inanition - Dehydration - Diabetes</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 26</b> , 19 <b>77</b> , to <b>Jan</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>Jan 26</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Richard A. Yates</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/30/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard A. YATES</b>		22e. ADDRESS <b>OLNEY, Md.</b>			
23a. BURIAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>2-2-77</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Md. National Mem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Laurel Pr Geo. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>		24b. ADDRESS <b>246 N. Wash. St. Rockville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1977</b>	25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>

BP

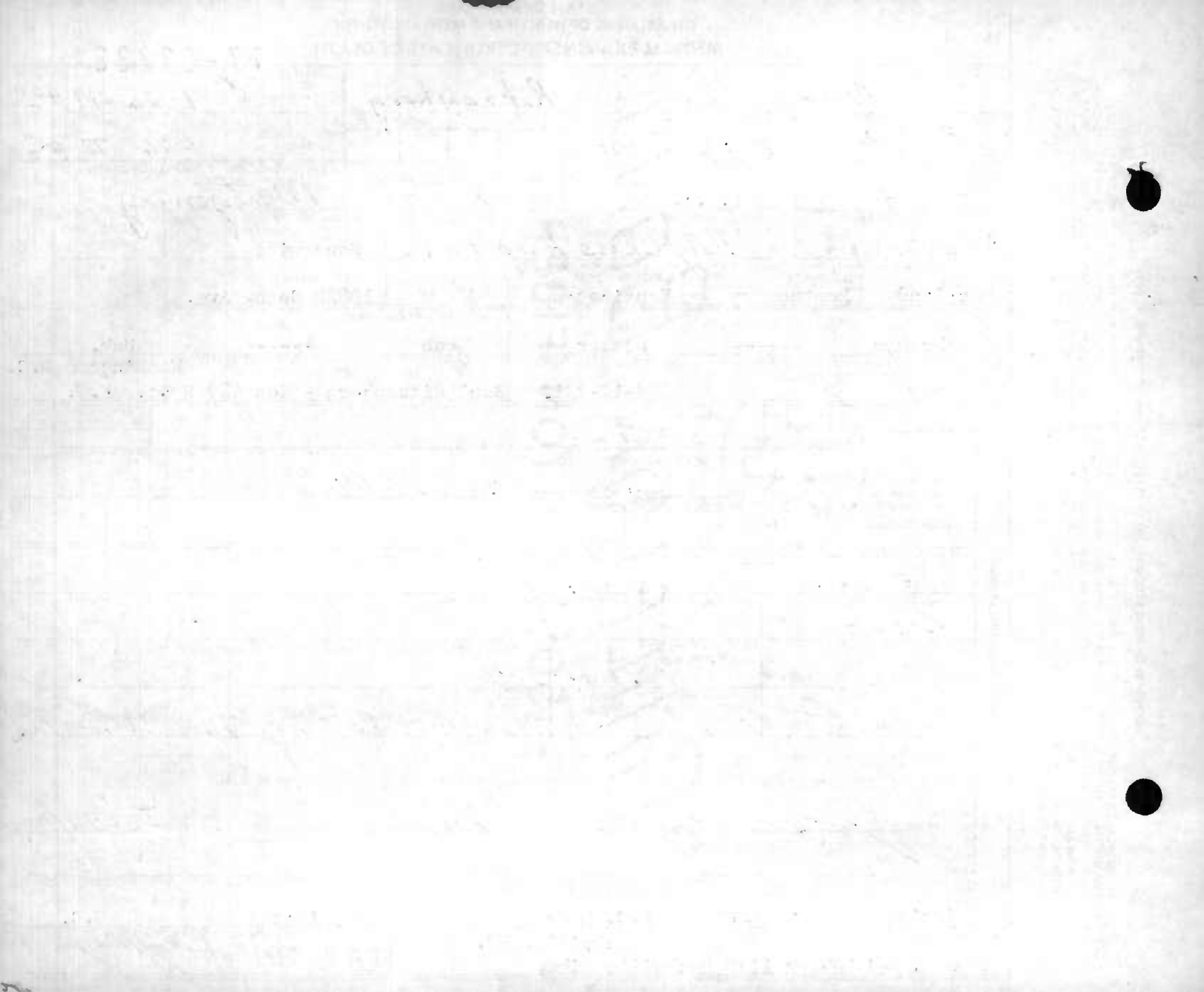
17-12-1955

*[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 02233	
1. DECEASED NAME (TYPE OR PRINT) <b>ANNA RUTH RITZENBERG</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1-26-77		2b. HOUR 4:50 AM			
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 8-12-01-25	6. AGE (IN YEARS) LAST BIRTHDAY 25 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 7 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD 1-26-77		2d. HOUR 4:50 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Kensington			
14. FATHER'S NAME FIRST MIDDLE LAST Abraham ----- Messer						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Leah ----- Unk.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 579-12-2213		17. INFORMANT ADDRESS Washington, D.C. Saul Ritzenberg - Son 429 N St., N.W.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>582v Uremia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Renal Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Fracture Rt. humerus</u>											
19a. DATE OF OPERATION <u>None</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 1-23-77			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Fall</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Nursing Home</u>			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <u>Jones Mill Rd Cherry Chase Mont, Md</u>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>John P. Rogers</u>						TITLE (SPECIFY) M.D. <u>Per</u>			DATE SIGNED Jan 26 1977		
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1-28-77		23c. NAME OF CEMETERY OR CREMATORY D.C. Lodge			23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.			
24. FUNERAL DIRECTOR NAME ADDRESS Danzansky-Goldberg 1170 Rockville Pike, Rockville, Md.						25a. DATE REC'D. BY REGISTRAR FEB 2 1977		25b. REGISTRAR'S SIGNATURE <u>Anthony McCree</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. <b>77-02234</b>								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Phillip Lane Robertson</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>January 29, 1977</b>			2b. HOUR <b>7:05 A M</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 2, 1964</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>12</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>				
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Institutes of Health</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		
13a. STATE <b>Illinois</b>					13b. COUNTY <b>Marion Co.</b>		13c. CITY OR TOWN <b>Salem</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James D. Robertson</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gloria - Copley</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>The Medical Record The Clinical Center, NIH, Bethesda, Md</b>						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Daunomycin Cardiotoxicity</b> <b>2050</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Sepsis Unknown Etiology</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myelogenous Leukemia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>1 month</b> <b>10 months</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>29 December</b> , 19 <b>76</b> , to <b>29 January</b> , 19 <b>77</b> , that <input checked="" type="checkbox"/> (we) lost <input type="checkbox"/> (we) (did not) view the body after death.										
22b. SIGNATURE <b>Gregory Reaman, MD</b> DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>								22c. DATE SIGNED <b>1/29/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GREGORY REAMAN</b>				22e. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Md 20014</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1/30/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rankin Funeral Home</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salem, Marion Co., Illinois</b>				
24. FUNERAL DIRECTOR NAME <b>CHAMBERS FUNERAL HOME</b>				ADDRESS <b>RIVERDALE, MARYLAND</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McBrody</b>		

BP

Phillips James Robertson January 22, 1977

Montgomery

Bethesda

The Medical Record  
The Clinical Center, NIH, Bethesda, MD

X 20 January 77  
X 20 December 76  
X 20 January 77

The Clinical Center, National  
Institutes of Health, Bethesda, MD 20814



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.DHMH - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) ROBERT EDMUND ROBINSON JR.						2a. DATE OF DEATH MONTH DAY YEAR JANUARY 01 1977		2b. HOUR 0125am	
3. SEX Male		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCTOBER 05 1898		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NATIONAL NAVAL MEDICAL CENTER				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) (Retired) Office		12b. KIND OF BUSINESS OR INDUSTRY Military (Navy)	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE DIST. of		13b. COUNTY COLUMBIA		13c. CITY OR TOWN WASHINGTON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2022 Columbia Rd. NW 20009	
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT EDMUND ROBINSON SR.					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST KATHERINE NMN STEELE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) WW1 & WWII		16c. INFORMANT Charlotte G. (Wife)		16d. ADDRESS Robinson. Same as item 13.3			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEMOCHROMATOSIS-ASCITES</u> 2732 Conditions, if any, which gave rise to immediate cause (a): stating the underlying cause last b) _____ DUE TO, OR AS A CONSEQUENCE OF c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>21 DEC 76</u> , 19____, to <u>01 JAN 77</u> , 19____, that (1) (we) last saw the deceased alive on <u>01 January</u> , 19 <u>77</u> , and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE L. A. Bucklew				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 01 JAN 77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. A. BUCKLEW CDR MC USNR				22e. ADDRESS BETHESDA, MD. NATIONAL NAVAL MEDICAL CENTER					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1/4/1977		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Va.			
24. FUNERAL DIRECTOR NAME JOSEPH GAWLER SONS NW, WASHINGTON, DC				5130 WISCONSIN AVE		25a. DATE REC'D. BY REGISTRAR JAN 5 1977		25b. REGISTRAR'S SIGNATURE Rickey McCready	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17-02236	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST KATHRYN ROSEMONT										2a. DATE KNOWN OF DEATH ESTIMATED 1/27/77 3:42 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 11 1895	6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD Jan 27 1977	2d. HOUR		2e. HOUR		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co. MD.					
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) TELEPHONE OPERATOR		12b. KIND OF BUSINESS OR INDUSTRY TELEPHONE		12c. TELEPHONE	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND										13b. CITY OR TOWN GREENSTOWN	
13c. COUNTY P.G. Co.										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 3119 QUEENS CHAPEL RD.											
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM ROSEMONT				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA NATKIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. NONE		17. INFORMANT PAUL CAREY				ADDRESS 6202 42 <sup>ND</sup> AVE. HYATTSVILLE MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 438X IMMEDIATE CAUSE (a) Acute Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Myocardial Dis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/yr											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John Rogers						TITLE (SPECIFY) M.D. Dep.			DATE SIGNED Jan 27, 1977		
EXAMINER'S NAME (TYPE OR PRINT) JOHN ROGERS						ADDRESS WHEATON, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/29/77		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD, P.G. Co. MD.			
24. FUNERAL DIRECTOR NAME CHAMBERS FUNERAL HOME						ADDRESS RIVERDALE, MD.		25a. DATE REC'D. BY REGISTRAR FEB 1 1977		25b. REGISTRAR'S SIGNATURE Henry McCreedy	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02237

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Morris B Rosenfeld</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-17-77</b>			2b. HOUR <b>850 A.M.</b>			
3. SEX <b>male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOV 28, 1894</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SALESMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>MD.</b>		13b. COUNTY <b>PRINCE GEO</b>		13c. CITY OR TOWN <b>HYATTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8105 14th AVENUE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ABRAHAM ROSENFELD</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ROSE UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>577-07-0974</b>		17. INFORMANT <b>NIECE</b> ADDRESS <b>KENSINGTON, MD.</b> <b>JOAN D. PRICE, 4201 DUNNELL LANE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metabolic Acidosis</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Uremia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>(Carcinoma of the Pancreas with Metastases plus</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Obstructive Lung Disease, Anemia, Hypochloremia, 1st Degree AV Block</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 days</b> <b>1 1/2 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic Obstructive Lung Disease, Anemia, Hypochloremia, 1st Degree AV Block</b>									
19a. DATE OF OPERATION <b>12/19/76</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Laparotomy for Carcinoma of the Pancreas with Metastases to Lung</b>				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER CAUSE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>on duty</b>		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>19-69</b> to <b>Jan 17</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>Jan 17</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Alan R. Gair MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/17/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alan R. Gair MD</b>						22e. ADDRESS <b>11700 Old Columbia Pike Silver Spring, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/19/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND PRI GEO MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick McCready</b>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 2 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-5600.

11-02237



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02238									
1. DECEASED NAME (TYPE OR PRINT) <b>HERMAN ROSENSTEIN</b>										2a. DATE OF DEATH MONTH <b>JAN</b> DAY <b>10</b> YEAR <b>1977</b>										2b. HOUR <b>3:14</b> PM									
3. SEX <b>MALE</b>					4. RACE <b>WHITE</b>					5. DATE OF BIRTH MONTH <b>12</b> DAY <b>21</b> YEAR <b>1908</b>					6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS					7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>					7. IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>					7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.														
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MERCHANT</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>									
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>MONTGOMERY</b>					13c. CITY OR TOWN <b>BETHESDA</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS <b>#20014 4400 East West Hwy #811</b>									
14. FATHER'S NAME FIRST <b>PHILIP</b> MIDDLE <b>ROSENSTEIN</b> LAST <b>LIBBY</b>					15. MOTHER'S MAIDEN NAME FIRST <b>LIBBY</b> MIDDLE <b>ROSEMAN</b> LAST <b>ROSEMAN</b>					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>XXXXXX NO</b>										16b. SOCIAL SECURITY NO. <b>XXXXXX NO</b>					17. INFORMANT <b>ROCKVILLE, MD 20854 LARRY ROSENSTEIN 23 OLD CREEK COURT</b>				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOGENIC SHOCK</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>ARTERIOSCLECTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 HR.</b> <b>5-10 YEARS</b>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>RENAL INSUFFICIENCY PERIPHERAL VASCULAR DISEASE ARTHRITIS</b>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 1976</b> to <b>1/10 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE <b>Ralph Coan</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED <b>1/10/77</b>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RALPH COAN M.D.</b>										22e. ADDRESS <b>4400 EAST WEST HWY BETHESDA, MD 20014</b>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>					23b. DATE <b>1-11-77</b>					23c. NAME OF CEMETERY OR CREMATORY <b>MIKRO KODESH-BETH ISRAEL</b>					23d. LOCATION CITY OR TOWN COUNTY STATE <b>BALTIMORE MARYLAND</b>														
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> NAME ADDRESS <b>6010 REISTERSTOWN RD., BALTO., MD 21215</b>										25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1977</b>					25b. REGISTRAR'S SIGNATURE <b>Therapy McCready</b>														

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02239  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LEVI</b>			2a. DATE OF DEATH MONTH <b>1</b> DAY <b>2</b> YEAR <b>77</b>			2b. HOUR <b>12:30AM</b>				
3 SEX <b>MALE</b>		4 RACE <b>NEGRO</b>		5 DATE OF BIRTH MONTH <b>4</b> DAY <b>8</b> YEAR <b>96</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD				
10 CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Collingswood Nursing Center</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>MD.</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>200 Norwood Road</b>	
14 FATHER'S NAME FIRST <b>UNKNOWN</b> MIDDLE <b>UNKNOWN</b> LAST <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Louvenia</b> MIDDLE <b>HART</b> LAST <b>HART</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>1</b>			16b. SOCIAL SECURITY NO. <b>220-54-2350-11</b>		17. INFORMANT ADDRESS <b>Alice Thomas - same as #13</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1922</b> <b>UREMIA due to URINARY Tract infection</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>COND, AND BONES - METASTATIC ADENOCARCINOMA of SPINAL</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sev. Monoph.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>32 days</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>PNEUMONITIS, ANEMIA, R. Hemiplegia</b>										
19a. DATE OF OPERATION <b>—</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>—</b> <b>—</b> <b>19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>			21f. LOCATION STREET <b>—</b> CITY OR TOWN <b>—</b> COUNTY <b>—</b> STATE <b>—</b>				
22a. I certify that (I) (this hospital) attended the deceased from <b>12-23</b> , 19 <b>76</b> , to <b>1-1</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>12-31</b> , 19 <b>76</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Roland Imperial MD</b>			DEGREE <b>MD</b>			22c. DATE SIGNED <b>1-2-77</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROLAND IMPERIAL MD</b>			22e. ADDRESS <b>4977 BATTERY LANE Bethesda MARYLAND.</b>							
23a. BURIAL-CREATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1-5-76</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ash Mem. Cem.</b>		23d. LOCATION CITY OR TOWN <b>Sandy Spring</b> COUNTY <b>Montg</b> STATE <b>MD.</b>			
24. FUNERAL DIRECTOR NAME <b>George N. Snowden</b> ADDRESS <b>440 N. WASH. ST. Rockville Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 6 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Helen M. Cuddy</b>					

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO : DIRECTOR, FBI (100-441100)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

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97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]



**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

REG. NO. **37-02240**

**1- FOR  
STATE  
REGISTRAR**

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>Miles</b>		MIDDLE <b>F</b>		LAST <b>Rouse</b>		2a. DATE KNOWN OF DEATH		MONTH <b>1</b>		DAY <b>27</b>		YEAR <b>1977</b>		2b. HOUR <b>7 A</b>	
3. SEX <b>Male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>7-12-1903</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>73 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD <b>Jan. 27 1977</b>		MONTH DAY YEAR		2d. HOUR <b>7 A</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wisconsin</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.											
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>D.C. Gov't.</b>					
13a. STATE <b>Md.</b>				13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Glen Echo Hgts.</b>				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6225 Walhonding Road</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert M. Rouse</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Hanson</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>577-56-4405</b>		17. INFORMANT <b>Agnes M. Rouse</b>				ADDRESS <b>Same as 13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiac Vascular Disease</b> <b>4/22</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE <b>John G. Ball</b>				TITLE (SPECIFY) <b>Deputy</b>				MEDICAL EXAMINER				DATE SIGNED <b>Jan 27, 1977</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>				ADDRESS <b>Bethesda, Maryland</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Jan. 31, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Mem. Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Va.</b>							
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>				ADDRESS <b>Homes, P.A. Bethesda, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1977</b>				25b. REGISTRAR'S SIGNATURE <b>Dickey McCreedy</b>					

**MEDICAL CERTIFICATION**

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02241

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Albert Joseph Routhier</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-13-77</b>		2b. HOUR <b>4:13 AM</b>				
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>1-16-04</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>72 72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NH</b>		7b CITIZEN OF WHAT COUNTRY? <b>American</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MAINTENANCE) <b>Post Office</b>		12b KIND OF BUSINESS OR INDUSTRY <b>U.S. Post off.</b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <b>D.C. -- Washington</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>7019 Georgia Ave. N.W.</b>			Zip-20012	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Routhier</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie Lagacy</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>none</b>		17 INFORMANT ADDRESS <b>Florence Routhier-wife-same- TA</b>		Phone <b>9-6246</b>		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>0092 MYOCARDIAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF <b>ANEMIA, MALNUTRITION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>GASTROINTESTINAL BLEEDING REGIONAL ENTERITIS - DIARRHEA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>WEEK.</b> <b>SEVERAL MONTHS</b> <b>2 YEARS.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>100% CERVICAL VASCULAR THROMBOSIS LEFT HEMLYMBIC HYPERTENSION</b>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 19 69</b> to <b>JAN 19 77</b> , that (I) (we) last saw the deceased alive on <b>JAN 19 77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert L. Krichmar</b>						DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>JAN. 13/1977</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT L. KRICHMAR</b>						22e. ADDRESS <b>7733 ARASKA AVENUE NW WASHINGTON D.C. 20012</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan. 17, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Montgomery Md.</b>		
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc., 8434 Ga. Ave., S.S. Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robert L. Krichmar</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02242	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Carrie A Royster						2a. DATE OF DEATH MONTH DAY YEAR JAN. 21 1977				2b. HOUR 3:30 A.M.	
3. SEX F.		4. RACE B.K.		5. DATE OF BIRTH MONTH DAY YEAR 3 30 1892		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wildwood Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE D.C.						13b. COUNTY		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST SAUL ARRINGTON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susie ARRINGTON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT MRS. Carolyn Carter		ADDRESS 4011 18th St. N.W.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 342X IMMEDIATE CAUSE (a) Respiratory infection DUE TO, OR AS A CONSEQUENCE OF (b) Parkinson's Disease, Diabetes DUE TO, OR AS A CONSEQUENCE OF (c) ASHD.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ASHD Anemia, Cataract.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. X 19 77		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) X					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) X		21f. LOCATION STREET CITY OR TOWN COUNTY STATE X					
22a. I certify that (I) (this hospital) attended the deceased from 11th Dec. 1976, to 1/21/77, 1977, that (I) (we) last saw the deceased alive on 19th Dec 77, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S.B. Goswami MD						DEGREE MD		22c. DATE SIGNED 1/21/77		22d. PHYSICIAN'S NAME (TYPE OR PRINT) SURYABALA B. GOSWAMI	
22e. ADDRESS 4721 River Road Bethesda Md 20014											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Removal				23b. DATE 1/25/77		23c. NAME OF CEMETERY OR CREMATORY Union Hill Bapt. Church, Nashville, Tenn		23d. LOCATION CITY OR TOWN COUNTY STATE Nashville, Tenn			
24. FUNERAL DIRECTOR NAME Hall Bros.						ADDRESS 621 Fla. Ave. N.W. Wash. D.C.		25a. DATE REC'D BY REGISTRAR JAN 24 1977		25b. REGISTRAR'S SIGNATURE Anthony McCrady	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

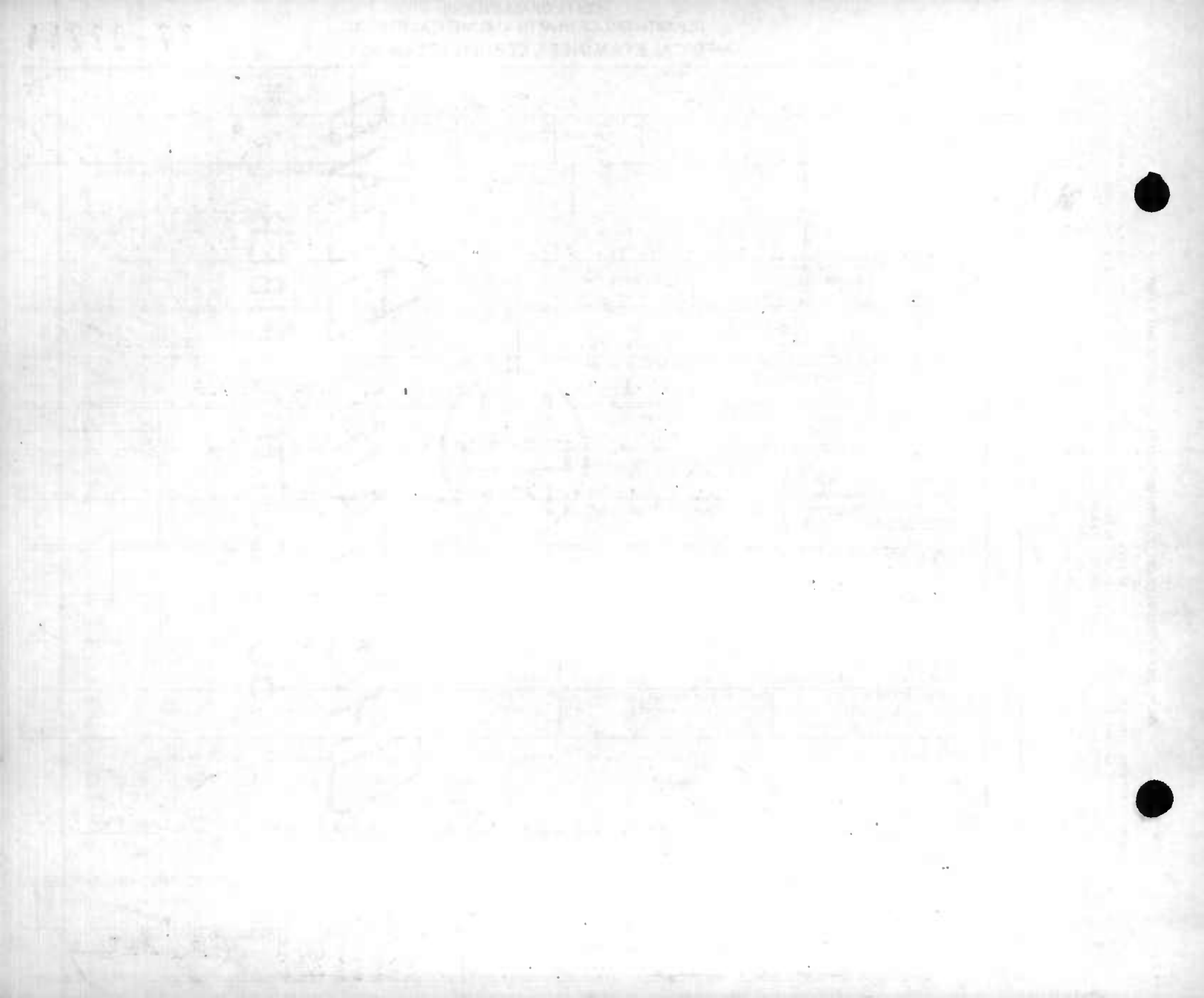
## MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 77-02243	
1- FOR STATE REGISTRAR										26. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EUGENE H RUARK										26. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 77 20 19	
3. SEX Male		4. RACE Caus		5. DATE OF BIRTH MONTH DAY YEAR April 14 94		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 82		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hall Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate Sales		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md		13b. COUNTY Mont		13c. CITY OR TOWN Silver Spg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 9411 Riley Pl.			
14. FATHER'S NAME FIRST MIDDLE LAST Henry W. Ruark				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Rebecca Leland							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. W.W.L 577-28-3246		17. INFORMANT ADDRESS Mary C. Ruark, 9411 Riley Pl. Silver Spring					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: H288 IMMEDIATE CAUSE (a) Acute Myocardial Dis. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. } (b) Chronic Myocardial Dis (c) } DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE [Signature]						TITLE (SPECIFY) M.D. [Signature]			DATE SIGNED Jan 20 1977		
EXAMINER'S NAME (TYPE OR PRINT)						ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 22, 1977		23c. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery, Cambridge, Dor., Md.				23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Kenneth P. Shoumat ADDRESS						25a. DATE REC'D. BY REGISTRAR JAN 25 1977			25b. REGISTRAR'S SIGNATURE [Signature]		

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 77-02244	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward F. Ryan Jr.										2a. DATE KNOWN OF DEATH MONTH DAY YEAR Jan 23 1977	
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 12 26 21	6. AGE (IN YEARS) LAST BIRTHDAY 55 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan 23 1977		2b. HOUR 11:05 AM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mont. General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Adv. & Pro. Dir.		12b. KIND OF BUSINESS OR INDUSTRY NBC TV			
13a. STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3754 Bel Pre Road, #2			
14. FATHER'S NAME FIRST MIDDLE LAST Edward F. Ryan, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geraldine Brilbeck							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes				16b. SOCIAL SECURITY NO. 068-16-3632		17. INFORMANT ADDRESS Elizabeth E. Ryan, see #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last.</u> (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>None</u>											
19a. DATE OF OPERATION <u>None</u>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John S. Rogers</u>				TITLE (SPECIFY) M.D.		MEDICAL EXAMINER		DATE SIGNED Jan 23, 1977			
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/27/77		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION CITY OR TOWN Silver Spring Md		COUNTY STATE			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home, Inc.				25a. DATE REC'D. BY REGISTRAR JAN 31 1977		25b. REGISTRAR'S SIGNATURE <u>Dorothy McCready</u>					
11800 New Hampshire Ave., Silver Spring, Md.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMM - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02245

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>FANNIE (TENNER) SADEL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>SUN JAN 23 77</b>		2b. HOUR <b>2 14</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 19, 1891</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hosp.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery COUNTY MD.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		#20875	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MAX TENNER</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>KATE HANKIN</b>		13e. STREET ADDRESS <b>6125 MONTROSE RD., ROCKVILLE, MD.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>APT. 706 WILMINGTON, DEL 19809</b> <b>HARRY TENNER 302 SHIPLEY RD., BLDG. 7</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>14329</b> IMMEDIATE CAUSE (a) <b>CEREBRAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>CAROTID + CEREBRAL ARTERIOSCLEROSIS</b> PROB. YEARS. DUE TO, OR AS A CONSEQUENCE OF: (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7.8</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>16 JAN</b> , 19 <b>77</b> , to <b>23 JAN</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>22 JAN</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>DONALD FISHMAN</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>23 JAN 77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD FISHMAN</b>		22e. ADDRESS <b>5454 WISCONSIN AVE, CHEVY CH, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1-24-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ANSHE NEISEN</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROSEDALE BALTO MD.</b>					
24. FUNERAL DIRECTOR NAME <b>L. L. L. L.</b>		ADDRESS <b>6010 Reisterstown Rd.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1977</b>	
25b. REGISTRAR'S SIGNATURE <b>P. H. H. H.</b>					

21-22-12

RECEIVED

21-22-12

COTTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02246

1. DECEASED NAME (TYPE OR PRINT) Paul St. Miklossy			2a. DATE OF DEATH MONTH DAY YEAR January 29, 1977 3 <sup>29</sup> PM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov 6 1903	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS		7b. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) HUNGARY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10. CITY OR TOWN OF DEATH Bethesda	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TREASURER		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE MD.			13c. CITY OR TOWN BETHESDA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST JOSEF St. Miklossy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ESTHER TERE MY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 146-07-7192		
17. INFORMANT ADDRESS 5004 EISMERE AVE. BETHESDA, MD 20814			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> 4319 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Carcinoma of Stomach - Coronary Artery Disease</u>		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that: (1) (this hospital) attended the deceased from <u>1/28/77</u> 19 to <u>1/29/77</u> 19, that (1) (we) last saw the deceased alive on <u>1/28/77</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (2) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Henry C. Servoggs MD</u>			22c. DATE SIGNED <u>1/29/77</u>		22d. ADDRESS <u>5413 Cedar La Bethesda Md.</u>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 1/31/77		23c. NAME OF CEMETERY OR CREMATORY Metropolitan
23d. LOCATION CITY OR TOWN Alexandria			23e. COUNTY Virginia		23f. STATE
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home			25. DATE REC'D. BY REGISTRAR FEB 3 1977		26. REGISTRAR'S SIGNATURE <u>Henry C. Servoggs</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02247
1. FOR STATE REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Benjamin SANGER					2a. DATE OF DEATH MONTH DAY YEAR January 28 1977			2b. HOUR 1255P M		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR Oct. 6 1921		6 AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York City		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK OR BUSINESS CONCERNING LIFE) U.S. Marine Corps		12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Pr. George 13c. CITY OR TOWN Oxon Hill					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1512 Jarvis Avenue			
14 FATHER'S NAME FIRST MIDDLE LAST Isidore Sanger					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Wachshall					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 2		17 INFORMANT Mrs. Mildred Sanger		ADDRESS See item 13				
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myelogenous leukemia 2051 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Metastatic carcinoma of the breast									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I/ (this hospital) attended the deceased from Jan. 11, 1977, to Jan. 28, 1977, that I (we) lost saw the deceased alive on Jan. 28, 1977, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (do not) view the body after death.										
22b. SIGNATURE Robert N. Longfield MD					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Jan. 28, 1977			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert N. Longfield, M.D.					22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/30/77		23c. NAME OF CEMETERY OR CREMATORY KING DAVID MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE FALLS CHURCH, VIRGINIA				
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D. C.					25. DATE RECD BY REGISTRAR FEB 1 1977		25b. REGISTRAR'S SIGNATURE Robert N. Longfield			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

77-02248

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Rose			E.		Santilli	Month 1 Day 23 Year 77			4:20 PM		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR		
Female		White		1/23/17			60 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Washington, D.C.		U.S.A.					Montgomery Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during rest of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park			Washington Adv. Hosp.			Sales			Kay Jewlrs.		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland			Prince Georges			Laurel YES <input type="checkbox"/> NO <input type="checkbox"/>		7315 Laurel-Bowie Rd.			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Guilio Fralleone						Louise					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
No			578-34-4075			Gino Santilli, 4322 10th St., E. Moline, Ill.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State		
White <input type="checkbox"/> Not while at work <input type="checkbox"/>						8/2 76			1/23 77		
22a. I certify that (I) (this hospital) attended the deceased from 8/2 76, 19 to 1/23 77, that (I) (we) lost saw the deceased alive on 1/23 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE						DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Dr. Lewis Dennis										1/24/77	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
						831 Univ. Blvd. E., S.S., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			1/28/77		Gate of Heaven Cemetery Silver Spring, Md.						
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hines / Rinaldi Funeral Home Silver Spring, Md.						11800 New Hampshire Ave.		DATE		JAN 31 1977	



SPOKE WITH

MEDICAL EXAMINER

STATE OF MARYLAND

1- FOR NOT CORONERS  
STATE REGISTRAR CASE.DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02249

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Irineo A. Santos</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>January 22, 1977</b>		2b. HOUR <b>11:00pm</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 11 11</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Manila Philippines</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Philippines</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>65</b>		
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Benito Santos</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emelia Abad</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Rolando C. Santos, see item #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 22</b> 19 <b>77</b> to <b>JAN 22</b> 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>JAN 22</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <b>G. Schweitzer</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>JAN 22, 77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. SCHWEITZER</b>		22e. ADDRESS <b>MONTGOMERY GEN HOSP</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>1/27/77</b>		23c. NAME OF CEMETERY OR CREMATORY		
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home, Inc.</b>		25a. DATE REC'D. BY REGISTRAR <b>1/25/77</b>		25b. REGISTRAR'S SIGNATURE <i>Anthony M. ...</i>		
11800 New Hampshire Ave., Silver Spring, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Manila, Philippines</b>				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02250  
REG. NO.1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>EVA</b>		FIRST <b>L.</b>		MIDDLE <b>SAPOZNICK</b>		2a. DATE OF DEATH MONTH <b>1</b> DAY <b>9</b> YEAR <b>77</b>		2b. HOUR <b>6<sup>30</sup> PM</b>	
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH <b>1</b> DAY <b>11</b> YEAR <b>15</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY CTY</b> MD.			
10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Association</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <b>MD</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST <b>John</b> MIDDLE <b>-----</b> LAST <b>Lunsford</b>		15 MOTHER'S MAIDEN NAME FIRST <b>Ada</b> MIDDLE <b>-----</b> LAST <b>(unknown)</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>009-09-5686</b>		17 INFORMANT ADDRESS <b>Wheaton, Md.</b> <b>Jacob L. Sapoznick - 3506 Weller Road</b>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Rupture (Possible)</b> <b>4109</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-8</b> , 19 <b>77</b> , to <b>1-9</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1-9</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Rajindra K. Sarin MBBS</b>		DEGREE <b>MBBS</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/10/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RATINDRA K SARIN</b>		22e. ADDRESS <b>6201 Greenbelt Rd College Park Md.</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-12-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Norbeck Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>Norbeck, Montg., Md.</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg 1170 Rockville Pike</b>		ADDRESS <b>Rockville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick McCreedy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed - this 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

Cleared by Dr. Rogers, Medical Examiner

MEDICAL CERTIFICATION



77-02220





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										77-02251 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Betty J. Sauter</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 23 1977</b>			2b. HOUR M <b>7:55 P. M.</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3 6 32 44 YRS.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>44</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. <b>1 23 19 77</b>		2c. DATE PRONOUNCED DEAD <b>1 23 19 77</b>	
7a. PLACE OF BIRTH <b>Washington D. C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Md.</b>						13b. COUNTY <b>Prince George's</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Oscar H Burton</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary E. Lethbridge</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>579-36-1629</b>		17. INFORMANT ADDRESS <b>Ralph H. Sauter (husband) same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Multiple drug intoxication</b> IMMEDIATE CAUSE (a) <b>Multiple drug intoxication</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Carcinoma of breast</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>? P.M. ? 19</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>took overdose of drugs</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7009 High View Terr. Hyattsville P. George Md.</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Insection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>H. R. Guard</i>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>1/25/77</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>1/27/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood P. G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons, PA Hyattsville, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1977</b>		25b. INITIALS OF REGISTRAR <i>Barney McCreedy</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02252  
REG. NO.

1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>James Alfred Scaggs</b>			1-31-77			2:15 AM			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-2-96</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>American</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <del>Widowed</del> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Prince Geo.</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1005 Montgomery St.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James A. Sceggs, Sr.</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Annie E. Beall</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>No</b>		16b. SOCIAL SECURITY NO. <b>705-09-1050</b>		17. INFORMANT ADDRESS <b>Hazel B. Kidwell-sister-same</b>	
								Phone <b>725-2044</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b> 1538 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 26 1977</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) (this hospital) attended the deceased from <b>1/30</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (ii) (we) (did not) view the body after death.									
22b. SIGNATURE <b>Ches. B. Rind</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/31/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 3, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ivy Hill Cemetery</b>		23d. LOCATION <b>Laurel, Maryland</b>		STATE
24. FUNERAL DIRECTOR NAME <b>Donaldson Funeral Home, Laurel, Md</b>						25a. DATE REC'D. BY REGISTRAR <b>FEB 4 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McCready</b>	

MEDICAL CERTIFICATION

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02253

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>LOUISE PAULINE SCANLON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-1-77</b>			2b. HOUR <b>4:00 AM</b>			
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>DEC. 20-1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD			
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONT-</b> 13c. CITY OR TOWN <b>COLESVILLE</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6 DURANT COURT</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM DASSAU</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LORETTA TITUS</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>WM/J. SCANLON</b> ADDRESS <b>6913 EMERSON ST. HYATTSVILLE-MD. 20784</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Respiratory Insufficiency</b> 5193 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Acute Obstructive Lung Disease</b> (c) <b>Mediastinal Neoplasm-type Unknown</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b> <b>3 weeks</b> <b>3 mos.</b>	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Stokes Post Obstructive Cardiomyopathy of Rt. Ventricle, Diabetic Mellitus</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>11 25 76</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>12/25</b> 19 <b>76</b> to <b>1/1</b> 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>12/31</b> 19 <b>76</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)									
22b. SIGNATURE <b>Howard W. Kennedy, M.D.</b>					DEGREE		22c. DATE SIGNED <b>1/1/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HOWARD W. KENNEDY, M.D.</b>					22e. ADDRESS <b>1111 Spring St. Silver Spring, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>1/4/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING-MONT-MD</b>		
24. FUNERAL DIRECTOR NAME <b>W.W. CHAMBERS Co. MARYLAND</b>					25a. DATE REC'D. BY REGISTRAR (TYPE OR PRINT) <b>JAN 10 1977</b>				

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02254

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <b>FRANK</b>		FIRST <b>SCHELL</b>		LAST	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SLIGO GARDENS NURSING HOME</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>GOVT. PRINT. OFF.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PRINTING-GOVT.</b>		13a. STREET ADDRESS <b>8505 SPRINGVALE ROAD</b>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16b. SOCIAL SECURITY NO. <b>145-10-2159 A</b>		17. INFORMANT <b>JOSEPHINE SCHELL</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>H379 IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>6 weeks</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>Chronic obstructive pulmonary disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>May 19 75</b> to <b>1-21 19 77</b> that (I) (we) last saw the deceased alive on <b>1-18 19 77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.		22b. SIGNATURE <b>Jason Belger, M.D.</b>		22c. DATE SIGNED <b>1-22-77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JASON BELGER, M.D.</b>		22e. ADDRESS <b>2830 CAMERON STREET SILVER SPRING, MD. 20910</b>		22f. REGISTRAR'S SIGNATURE <b>Patrick McCready</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1-23-1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan</b>	
23d. LOCATION CITY OR TOWN <b>Alexandria</b> COUNTY <b>Fairfax</b> STATE <b>Virginia</b>		24. FUNERAL DIRECTOR <b>Francis J. Collins 500 Univ. Blvd. W. Silver Spring Maryland 20901</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 26 1977</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 71 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examination must be certified at once.



55-05524

INVESTIGATION

TEXAS PARK

1-25-1977

Branch 1, Dallas 400 Univ. Blvd. N.

Silver Spring, Maryland 20910



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 77-02255

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
James Powers Seward Jr			1-25-77			A M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
Male	White	1-4-1936	40 YRS.			Jan 26 1977	5:30 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash. D.C.	U.S.A.				Montgomery MD.			

10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Gaithersburg		9701 Fields Rd.		Empire Music Co.		Records	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Md.	Montgomery	Gaithersburg	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	9701 Fields Rd.			

14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
James Powers	Seward	Mae S.	Reynolds

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT
No	Not available	4418 Presidio Dr, Simi Valley, Calif.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Head.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last.</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
--	--	--

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 1 25 77		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot self in foot of mouth with gun	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) apartment		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 9701 Fields Rd. Gaithersburg Montgomery Md.	

22a. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐.

ACTUAL SIGNATURE	TITLE (SPECIFY)	DATE SIGNED
John G. Ball	M.D. Deputy	Jan. 26, 1977
EXAMINER'S NAME (TYPE OR PRINT)	ADDRESS	
John G. Ball	Old Georgetown Rd., Bethesda, Md	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
BURIAL	1-31-77	Rappanannack Christian Church Cem.	Rappannock, Virginia
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md.	FEB 3 1977		Patrick McCreedy



CLEARED BY MEDICAL EXAMINER - DR. J. J. JOHNS

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

DHMH - 16 50M 1/76  
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02256

1. DECEASED NAME (TYPE OR PRINT) IRMA LOIS SCHIFF			2a. DATE OF DEATH MONTH DAY YEAR January 20, 1977			2b. HOUR 4:40 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 25, 1943		6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14108 Northwyn Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Transportation			
13a. STATE Maryland			13b. COUNTY P. G.		13c. CITY OR TOWN Adelphi		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Harry David Schiff			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Stella Swiebaum			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 232-72-2363			17. INFORMANT Jerome Schiff			18. ADDRESS 14108 Northwyn Drive, Silver Spring, Maryland			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic breast cancer 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF b) DUE TO, OR AS A CONSEQUENCE OF c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <u>June 7, 1974</u> to <u>Jan. 14, 1977</u> , that (2) (we) lost <u>her</u> <u>on</u> <u>March 76</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE BARRY N. ROSENBAUM, M.D.			DEGREE			22c. DATE SIGNED 1/20/77		22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY N. ROSENBAUM, M. D.	
22e. ADDRESS 3720 FARRAGUT AVE. KENSINGTON, MD. 20795			23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL						
23b. DATE 1/21/77			23c. NAME OF CEMETERY OR CREMATORY JUDEAN MEMORIAL GARDEN			23d. LOCATION CITY OR TOWN COUNTY STATE OLNEY MONTGOMERY MARYLAND			
24. FUNERAL DIRECTOR NAME D. M. STEIN			24b. ADDRESS 232 CARROLL STREET, N.W., WASHINGTON, D.C.			25a. DATE REC'D. BY REGISTRAR JAN 26 1977			
25b. REGISTRAR'S SIGNATURE [Signature]			25c. REGISTRAR'S NAME [Name]						

MEDICAL CERTIFICATION

X  
X

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7302 BP [Signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LAIRD BYER SCOTT</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 26 1977</b>		2b. HOUR <b>9:54 A.M.</b>	
3 SEX <b>M</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>1 1 13</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Scotland</b>		7b. CITIZEN OR WHAT COUNTRY? <b>USA American</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>			
10 CITY OR TOWN OF DEATH <b>Seasma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Painter</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3416 - Greenacres Rd -</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Richard Scott</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Knight</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-26-0945</b>		17. INFORMANT <b>Luella S. Scott. (13e)</b>		ADDRESS			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4400</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSIVE AND ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>15 YEARS</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES MELLITUS</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 19 62</b> to <b>JAN 26 19 77</b> , that (I) (we) last saw the deceased alive on <b>JAN 26 19 77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert L. Krichmar M.D.</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>JAN 26/1977</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT L. KRICHMAR M.D.</b>				22e. ADDRESS <b>7733 ANAKA DRIVE NW WASHINGTON D.C. 20012</b>					
23a. BURIAL, CREMATION, ETC. (TYPE OR PRINT) <b>Funeral Home</b>		23b. DATE <b>JAN 31-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Willow Lutheran Ch.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Willow Penna.</b>			
24a. FUNERAL DIRECTOR <b>Funeral Home</b>				24b. ADDRESS <b>254 Carroll St NW</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 2 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patricia McQuinn</b>	

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**IMPORTANT:** If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02258

1 - STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 77-02258					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELSIE H SEITZ					2a. DATE OF DEATH MONTH DAY YEAR 1 25 77				2b. HOUR 12 30 PM		
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 8 19 1981		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Towson MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD					
10. CITY OR TOWN OF DEATH GaitHERsburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wilson Health CARE Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Robert Levi Holland					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA William son						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT ADDRESS Admission OFFICE							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Dis</u> 15 yrs. DUE TO OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> 25 yrs.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I): <u>Chronic organic brain syndrome due to arteriosclerotic dis.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>3/1/63</u> 19 <u>  </u> to <u>1/25/77</u> 19 <u>  </u> , that (I) (we) lost saw the deceased alive on <u>1/20/77</u> 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Henry C. Scruggs</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/25/77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry C. Scruggs MD				22e. ADDRESS 5413 Cedar La Bethesda Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/27/77		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Pikesville Md.			
24. FUNERAL DIRECTOR NAME A. Alan Seitz Jr.				3818 Roland Ave.		25a. DATE REC'D. BY REGISTRAR JAN 27 1977		25b. REGISTRAR'S SIGNATURE <u>Henry C. Scruggs</u>			



02152-15

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified of occurrence.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 77-02259			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>John V. Shawl</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 11 77</b>				2b. HOUR MIN <b>7A</b>
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 22 1963</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>W. VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MEAT PLANT</b>	
13a. STATE <b>MD.</b>		13b. COUNTY <b>MONTG.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>14648 KelmScott Drive</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Shaull</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lelia FRY</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					16b. SOCIAL SECURITY NO. <b>577-09-2730 A</b>		17. INFORMANT ADDRESS <b>GRACE Shaull 14648 KelmScott Drive SS. MD.</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>H123</b> IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>12/24</b> , 19 <b>76</b> , to <b>1/11</b> , 19 <b>77</b> , that (1) (we) last saw the deceased alive on <b>1/11</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Ira Tauber</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>11/1/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ira Tauber</b>				22e. ADDRESS <b>10301 Georgia Ave., Silver Spring Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/14/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hillsboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hillsboro, Virginia</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>HINGS/RINALDI 11800 NEW HAMPSHIRE AVE SSMD</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 18 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCurdy</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02260	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST FLORENCE SIMON						2a. DATE OF DEATH MONTH DAY YEAR January 22 1977			2b. HOUR 3:15 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 29 <sup>th</sup> , 1896		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Health Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6530 Democracy Boulevard			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda							
14. FATHER'S NAME FIRST MIDDLE LAST Boris Sobell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie (Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) (Unknown)		17. INFORMANT ADDRESS Leroy Simon 10401 Grosvenor Lane, Rockville, Maryland					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMOCOCCAL PNEUMONIA 4379 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC CEREBROVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) MORE THAN 10 YEARS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HOURS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from JUNE 19 77 to 1/22 19 77, that (1) (we) lost saw the deceased alive on 1/21 19 77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S. Ralph Himmelhoch, M. D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 1/22/77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 50 West Edmonston Drive, Rockville, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/24/77		23c. NAME OF CEMETERY OR CREMATORY Mount Sharon		23d. LOCATION CITY OR TOWN COUNTY STATE Philadelphia, Delaware, Pa.			
24. FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW NEM. FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.						25a. DATE REC'D. BY REGISTRAR JAN 26 1977		25b. REGISTRAR'S SIGNATURE Ruthy McCready			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 02261			
1. DECEASED NAME (TYPE OR PRINT) Edward Elliot Sinclair												2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1-10-76		2b. HOUR 7:15 PM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 3-4-22		6. AGE (IN YEARS) LAST BIRTHDAY 54 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan. 10 1976		2d. HOUR 7:55 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MASS.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Germantown.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ERDA Building Route 270				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADM. ASST.				12b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT			
13a. STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Derwood.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 18610 Azalea Dr					
14. FATHER'S NAME FIRST MIDDLE LAST Howard - Sinclair						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Janda									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 0077		17. INFORMANT Mrs. Edward E. Sinclair Same as #13				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4124 IMMEDIATE CAUSE (a) Coronary Insufficiency Acute Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Cardio Vascular Disease (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE John G. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER Old Georgetown Rd. Bethesda, Md.				DATE SIGNED Jan 11, 1977			
EXAMINER'S NAME (TYPE OR PRINT) John G. Ball				ADDRESS Old Georgetown Rd. Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 13, 1977		23c. NAME OF CEMETERY OR CREMATORY Laytonsville				23d. LOCATION CITY OR TOWN COUNTY STATE Laytonsville Mont. Md.					
24. FUNERAL DIRECTOR NAME Francis H. Barber				ADDRESS Laytonsville, Md. 20760				25a. DATE REGD. BY REGISTRAR JAN 17 1977		25b. REGISTRAR'S SIGNATURE Markus McCready					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

5903 DHMM, 16 1/71 30M (VR A15 (4))

# DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>HORACE E. SLONE</b>			2a. DATE OF DEATH Month <b>LAN</b> Day <b>16</b> Year <b>1977</b>			2b. HOUR <b>1:30 P.M.</b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>January 28, 1906</b>		6. AGE (In years last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6005 Landon Lane</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6005 Landon Lane</b>	
14. FATHER'S NAME First Middle Last <b>Arthur P. Slone</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>unknown</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) <b>no</b>			16b. (If yes give year or dates of service) <b>none</b>			17. INFORMANT <b>Annet J. Slone-wife- (same as 13e)</b>			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4121</b> IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ischemic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>16 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>asthmial hypotension</b>											
19a. DATE OF OPERATION <b></b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b></b>			21b. TIME OF INJURY HOUR A.M. Month Day Year <b></b> P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b></b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b></b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/19/76</b> , 19 <b>76</b> , to <b>1/16/77</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1/18/76</b> , 19 <b>76</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John M Evans MD</b>			DEGREE <b></b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>1/18/1977</b>		
22d. PHYSICIAN'S NAME (Type) <b>John M Evans</b>			22e. ADDRESS <b>5480 Wisconsin Ave</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Jan. 21, 1977</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mary's Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Amsterdam New York</b>		
24. FUNERAL DIRECTOR <b>Varner E. Humphrey, Inc., 8434 Ga. Ave., S.S. Md.</b>						25a. REC'D BY REGISTRAR <b>Clark E. Wisor</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick McCready</b>		DATE <b>JAN 24 1977</b>	

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Figure 1. 2

• *Journal of Management Education*

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02263  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Edgar Lynn Smith</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 1 77</b>			2b. HOUR <b>10</b>				
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 29 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>48</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Takoma Park, Maryland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Judge</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>County</b>		
13a. STATE <b>Md.</b>			13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Greenbelt</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>118 Green Hill Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>R. Van Smith</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ida Gertrude Prettyman</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>WW II 215-20-1177</b>		17. INFORMANT ADDRESS <b>Mrs. Paula P. Smith (wife) same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>71 11 22</b>					
22a. I certify that (I, this hospital) attended the deceased from <b>1977</b> to <b>11</b> 19 <b>77</b> that (I, we) last saw the deceased alive on <b>1977</b> and that in my (our) opinion death occurred on the date and hour and from the cause(s) stated above (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Lewis A. Dennis</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/1/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LEWIS A. DENNIS</b>			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>1/6/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Memory Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury, Wic., Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>HOLLOWAY FUNERAL HOME, Salisbury, Maryland</b>			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <b>JAN 10 1977</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17-05883



Montgomery

County

Indian

Washington Adventist Hospital

Capitola

Mrs. Paula P. Smith (wife) same as 13

WM 11

Yes

*Handwritten signature*

*Handwritten notes and signatures at the bottom of the page.*

HOLLYMAN FUNERAL HOME, Salisbury, Maryland  
1/10/77  
Salisbury, Maryland, Salisbury, Wic., Maryland

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										77-02264 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)						FIRST		MIDDLE		LAST	
Kimberly Ann Smith											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		7. IF UNDER 24 YRS. MONTHS DAYS HOURS MIN.		2a. DATE KNOWN OF DEATH ESTIMATED	
Female		White		Nov. 5, 1976		2		12		1 18 19 77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Maryland				U S A				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Olney				Montgomery General Hospital				None-infant			
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
Maryland				Montgomery		Silver Spring		YES		15524 New Hampshire Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Not available						Anna Marie Smith					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				None		Anna Marie Smith-Same as items 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden Infant Death Syndrome</u> 2950 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>Bert F. Morton</u>				TITLE (SPECIFY) <u>Deputy Chief</u>				DATE SIGNED <u>1/19/77</u>			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
Bert F. Morton, M.D.				111 Penn St., Baltimore, Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				1/21/77		Parklawn Memorial				Rockville, Mont., Md.	
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR			
W. W. Chambers Co., Silver Spring, Md.								JAN 28 1977			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director or other person authorized by the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director or other person authorized by the State Department of Health and Mental Hygiene prior to burial, cremation, or removal, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

3800 BP

DHMM - 16 50M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02265 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>LOTIE M. SMITH</b>										2a. DATE OF DEATH MONTH <b>Jan</b> DAY <b>4</b> YEAR <b>1977</b>		2b. HOUR <b>3<sup>30</sup></b> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/>	
3. SEX <b>F</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH <b>Dec</b> DAY <b>15</b> YEAR <b>1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>66</b> YRS		7. IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		7. IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.							
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>not employed</b>		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE <b>Md</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2308 Blue Ridge Ave.</b>					
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Thomas</b> LAST <b>Borris</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Venie</b> MIDDLE <b>Mulligan</b> LAST <b>Mulligan</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>213-58-6350</b>		17. INFORMANT <b>Marie Stevers-</b>				ADDRESS <b>#13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary atherosclerosis, primary arteriosclerosis</b> <b>1990</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>OCT 16</b> , 19 <b>76</b> , to <b>Jan 27</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>1/4</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Leon P. Andrews</b>				DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/4/77</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Leon P. Andrews</b>				22e. ADDRESS <b>Suburban Hospital, Bethesda</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-6-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Burtensville Union</b>		23d. LOCATION CITY OR TOWN <b>Burtensville</b> COUNTY <b>Montg.</b> STATE <b>Md.</b>							
24. FUNERAL DIRECTOR NAME <b>John H. Sandison</b> ADDRESS <b>316 E. Diamond Ave Gaithersburg, Md 20878</b>				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>JAN 10 1977</b> <b>[Signature]</b>									

MEDICAL CERTIFICATION

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

77-02266

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Mary Elizabeth Snyder</b>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <b>1-26-77</b>			2b. HOUR <b>2:30 P.M.</b>		
3. SEX <b>Fe.</b>	4. RACE <b>W.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11-16-22</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>54 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS <b>54</b>	IF UNDER 24 HRS. HOURS MIN <b>54</b>	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>Jan-26-77</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>OKLAHOMA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF-EMPLOYED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>POTTERY</b>
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>309 BRADLEY AVE.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>C. MABLE SMITH</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17. INFORMANT <b>DAVID SNYDER</b>		ADDRESS <b>514 SPRINGVIEW CT. JEFFERSON, MD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia.</b> 5710 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) <b>Gastric Hemorrhage.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cirrhosis of Liver</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>Chronic Alcoholism.</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH P.M. 19			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <b>John B. Ball</b>			TITLE (SPECIFY) <b>Deputy</b>			DATE SIGNED <b>Jan 27/1977</b>		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>REMOVAL</b>		23b. DATE <b>1-27-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GEORGETOWN MEDICAL SCHOOL</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>CHAMBERS FUNERAL HOME</b>			ADDRESS <b>8655 GEORGIA AVE. SILVER SPRING, MD.</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 1 1977</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMM-17  
(VR A15 ME (5))  
30M 7/73

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201





DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02267  
REC. NO.

1. FOR STATE REGISTRAR		2. DECEASED NAME (TYPE OR PRINT) <i>Alice E Solbach</i>		3. DATE OF DEATH MONTH <i>1</i> - DAY <i>20</i> - YEAR <i>76</i>		4. HOUR <i>12</i> P.M.	
3. SEX <i>FEMALE</i>		4. RACE <i>Caucas</i>		5. DATE OF BIRTH MONTH <i>10</i> - DAY <i>10</i> - YEAR <i>1916</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>80</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>	
10. CITY OR TOWN OF DEATH <i>L.S. Md</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MD</i> 13b. COUNTY <i>Mont</i> 13c. CITY OR TOWN <i>Rockville</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4704 Luster Rd.</i>			
14. FATHER'S NAME FIRST <i>Harry</i> MIDDLE <i>Sweeney</i> LAST <i>Sweeney</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Alice</i> MIDDLE <i>Sweeney</i> LAST <i>Sweeney</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>579-68-9763</i>		17. INFORMANT ADDRESS <i>4704 Luster Rd</i> <i>Robert John Rockville Md</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>H123</i> IMMEDIATE CAUSE (a) <i>Acute Coronary Thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF: (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (c) <i>Arteriosclerotic Generalized</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/19</i> , 19 <i>76</i> , to <i>1/20</i> , 19 <i>77</i> , that (I) (we) last saw the deceased alive on <i>1/20</i> , 19 <i>77</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Howard W. Kenney, M.D.</i>				DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>1/20/77</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Howard W. Kenney, M.D.</i>				22e. ADDRESS <i>111 S. 2nd St. Silver Spring, Md. 20910</i>			
23a. BURIAL, CREMATION, REMOVAL (REVIEW) <i>Burial</i>		23b. DATE <i>1/24/77</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wash National</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Southland Md. 20885</i>	
24. FUNERAL DIRECTOR NAME <i>East Hales S.A.</i>		ADDRESS <i>6160 Old Hales Rd Rockville, Md.</i>		25. DATE REC'D. BY REGISTRAR <i>JAN 26 1977</i>		25b. REGISTRAR'S SIGNATURE <i>Patricia McCreedy</i>	

MEDICAL CERTIFICATION

X  
X

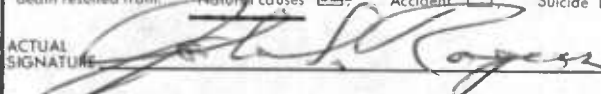
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be attached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10330-77

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH77-02268  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST JOHN	MIDDLE SHERMAN	LAST SPENCE JR.	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1 / 21 19 77		2b. HOUR 10:09 A. M.
3. SEX M.	4. RACE W.	5. DATE OF BIRTH MONTH DAY YEAR 2 15 25	6. AGE (IN YEARS) LAST BIRTHDAY 51 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 1 / 21 19 77	2d. HOUR 10:09 A. M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12603 Denley Road			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self Employed		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 12603 Denley Road		
14. FATHER'S NAME FIRST MIDDLE LAST John Sherman Spence Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva McLaurine			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT ADDRESS Mildred B. Spence, (same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic myocardial disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None							
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) None			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery, Md.		DATE SIGNED 1/21/77	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.		ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Jan. 24, 1977	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood G.D. Md.		
24. FUNERAL DIRECTOR NAME Takoma Funeral Home, J.D. Walter		ADDRESS 254 Cornell Dr NW		25a. DATE REC'D. BY REGISTRAR JAN 25 1977		25b. REGISTRAR'S SIGNATURE P. H. McCready	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 77-02269	
1. DECEASED NAME (TYPE OR PRINT) <b>Jiri (George) Marcel Srb</b>						2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR <b>1 25 19 77</b>		2b. HOUR <b>4:14</b>		M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 30 1953</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>23</b> YRS.		IF UNDER 1 YR. MONTHS DAYS <b>23</b>		IF UNDER 24 HRS. HOURS MIN <b>23</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Prague</b>				7b. CITIZEN OF WHAT COUNTRY? <b>Residence of USA Stateless</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>D.C.</b>				13b. COUNTY		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5036 Nebraska Ave., N.W.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Vaclav Srb</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hana Srbova</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO. <b>063-54-0026</b>		17. INFORMANT ADDRESS <b>Lubor Krafka, 5036 Nebraska Ave., N.W.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8160 IMMEDIATE CAUSE (a) Cranio-cerebral trauma</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3:30 1 25 77</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of auto lost control</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Highway</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Rockville Pike, Bethesda, Montgomery, Md.</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Bert F. Morton</b>				TITLE (SPECIFY) <b>Deputy Chief</b>				DATE SIGNED <b>1/26/77</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Bert F. Morton, M.D.</b>				ADDRESS <b>111 Penn St., Baltimore, Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>2/14/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Co. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Jos. Gawler's Sons 5130 Wisconsin Ave. N.W.</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Pistony McCreedy</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02270

1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) <i>Elizabeth Ann Stamm</i>		2b. DATE OF DEATH MONTH DAY YEAR <i>1 22 77</i>		2c. HOUR <i>6 45 AM</i>	
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>November 19, 1887</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>89</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>W. Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S. of Am.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>National Geographic Society</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Teacher</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Maryland</i>		13c. COUNTY <i>Prince Georges</i>		13d. CITY OR TOWN <i>Upper Marlboro</i>		13e. STREET ADDRESS <i>11411 Brown Rd.</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Abraham Stamm</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary O'Malley</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <i>NO</i>			
16b. SOCIAL SECURITY NO. <i>579 50 3036</i>		17. INFORMANT ADDRESS <i>Mary Alberta Bailey, 11411 Brown Rd., Upper Marlboro</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thromboses</i> 4123 DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASVD</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASVD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>11/13/77</i> <i>5 years</i> <i>18 years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Adenocarcinoma of colon removed by hemicolectomy (Meckel's Diverticulum)</i>							
19a. DATE OF OPERATION <i>January 13, 1977</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal Obstruction &amp; Intussusception</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDER <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>September 1976</i> to <i>January 22, 1977</i> , that (I) <del>last</del> saw the deceased alive on <i>January 22, 1977</i> , and that in (my) <del>low</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) (did not) view the body after death.							
22b. SIGNATURE <i>Walcott W. Gibson, MD</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>Jan. 22, 1977</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Walcott W. Gibson, M.D.</i>				22e. ADDRESS <i>4300 St. Barnabas Road, Marlow Heights, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>25 Jan 77</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Congressional Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Washington D. C.</i>	
24. FUNERAL DIRECTOR NAME <i>Robert E Wilhelm</i>				25a. DATE REC'D. BY REGISTRAR <i>FEB 1 1977</i>			
4308 Suitland Rd., Suitland, Md. 20023				25b. REGISTRAR'S SIGNATURE <i>Turkey McCurdy</i>			

07393-11



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02271

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR				
FIRST MIDDLE LAST META E STANCILL			MONTH DAY YEAR 1-16-77			7 <sup>15</sup> PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Female		White		MONTH DAY YEAR May 27, 1890		86 YRS.		IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Wisconsin		U.S.A.				Montgomery MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Kensington			Kesington Gardens N.H.			Ret. Secretary			U.S. Postal Service	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland			Mont.		Kensington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4019-Byrd Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST John - Becker			FIRST MIDDLE LAST Emilie - Harder							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS		
No			391-16-6757		Carl B. Stancill-son Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4123 IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS Disease DUE TO, OR AS A CONSEQUENCE OF (c) SENILITY Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from 1/16/77 to 1/16/77 that (2) I saw the deceased alive on 1/16/77, and that (3) my (our) opinion of death occurred on the date and hour and from the causes stated above, (4) (we) (did) (did not) view the body after death.										
22b. SIGNATURE			DEGREE			22c. DATE SIGNED				
Thos G. Ward M.D.						1-16-77				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
Thos G. WARD			6116 ROBINWOOD RD, Bethesda 3rd							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY			
Cremation			1-17-1977		Lee's Crematory		Washington, D.C.			
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Lee Fun. Home 300-4th St., NE, Wash., DC			JAN 20 1977			[Signature]				

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02272

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Ethel Steinberg</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1-16-77</b>			2b. HOUR <b>4<sup>40</sup> A.M.</b>		
3 SEX <b>female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 15 96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Grocery</b>	
13a. STATE <b>Dist. of Col.</b>				13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Steinberg</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Not Ascertainable</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>N/A.</b>		17. INFORMANT <b>Philip D. Simon Gaithersburg, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4123</b> IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic coronary artery disease 20 yrs.</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (the hospital) attended the deceased from <b>1977</b> , to <b>1977</b> , that (I) (we) lost saw the deceased alive on <b>1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.								
22b. SIGNATURE <b>Ronald L. Linder M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>1/16/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald L. Linder M.D.</b>				22e. ADDRESS <b>1106 Spring St. Silver Spring Md</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/18/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Virginia</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Donald M. Stein Hebrew Memorial F.H. 232 Carroll Street, N. W. Washington, D. C.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 21 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Ritney McCreedy</b>		

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02273	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Anne R Stevens						2a. DATE OF DEATH MONTH DAY YEAR Jan 3 1977			2b. HOUR 4 P.M.		
3. SEX Fe		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Dec 15 1888		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Ching Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BRNC 8700 Jones Mills Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md				13b. COUNTY Howard		13c. CITY OR TOWN Columbia		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 216 Concord House	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas J. Rowe				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Carol J. Shainfeldt 657-8688					
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Edema 4123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Premia and Arteriosclerosis Heart Disease (c) Generalized Arteriosclerosis PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b) Cerebral Arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from Dec 31 1976 to Jan 3 1977, that (I) (we) lost spw the deceased alive on Dec 31 1976, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22a. SIGNATURE E. Hersbert Bauersfeld MD						DEGREE MD		22c. DATE SIGNED 1/3/77		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Hersbert Bauersfeld MD						22e. ADDRESS 2401 Cleveland St NW					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE 1/4/77		23c. NAME OF CEMETERY OR CREMATORY Univ. of Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME Anatomy Board						25a. DATE REC'D. BY REGISTRAR JAN 7 1977		25b. REGISTRAR'S SIGNATURE Rickey McCreedy			

55-08519

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02274  
REG. NO.1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Charles F. Stevens</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1 23 77</b>			2b. HOUR <b>8:23</b> M				
3. SEX <b>M</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 24 93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alexandria, Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wash. Adventist Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret.-Guard- U.S. Gov't.</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>			13b. COUNTY <b>Pr. Geo.</b>		13c. CITY OR TOWN <b>Mt. Rainier</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3206-Chillum Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles H. Stevens</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Horseman</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WWI</b>		17. INFORMANT ADDRESS <b>2600-Queens Cnp</b>				17. INFORMANT ADDRESS <b>T Mrs. Dorothy Wade- Rd., Hy., Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac respiratory arrest</b> <b>4/23</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Coronary artery, rheumatic heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>&gt; months</b> <b>7 years</b>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (10) <b>Chronic obstructive pulmonary - Vascular tetralogy - Pneumonia R.L.</b>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>January 1, 1977</b> to <b>January 23, 1977</b> , that (I) (we) last saw the deceased alive on <b>January 23, 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Dr. G. Grazian M.D.</b>				DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>1-24-77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HUGO G. GRAZIAN M.D.</b>				22e. ADDRESS <b>800 Pershing Dr. 303 A, S.S. Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/26/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem.</b>		23d. LOCATION CITY OR TOWN <b>Suitland Pr. Geo. Md.</b>		COUNTY STATE		
24. FUNERAL DIRECTOR NAME <b>Nalley's F.H. Inc.</b>				ADDRESS <b>Mt. Rainier, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 27 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCready</b>		

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02275

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Henry Stevens</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>January 10 1977</b>		2b. HOUR <b>4:15 AM</b>	
3. SEX <b>male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 11 1896</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Vermont</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS MONTHS DAYS HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md. 20016</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>West Haven</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William H. Stevens</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Louise Fuller</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.D.A. Allergen Res.</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>579-03-3699</b>		17. INFORMANT <b>Daughter</b> <b>Joan Stevens Barleben, 3718 Dorsett Dr. Madison, Wis. 53711</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma, RLL of lung</b> 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>months</b>					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Pneumonia, cerebral vascular accident</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9 Jan 1977</b> to <b>10 Jan 1977</b> , that (I) (we) last saw the deceased alive on <b>9 Jan 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Horace Bernton, M.D.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/17/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Horace Bernton, M.D.</b>		22e. ADDRESS <b>5116 Brookview, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/12/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>		24. FUNERAL DIRECTOR NAME <b>JOSEPH J. BERRY, INC.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1977</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert McCready</b>		25c. ADDRESS <b>5130 Wisconsin Avenue, N.W.</b>			

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Sanjay, Anshu

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02276

REG NO

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Sarah W Stokes</b> <i>SARAH W STOKES</i>		2a. DATE OF DEATH MONTH DAY YEAR <b>1 18 77</b> <i>9 10</i>	
3 SEX <b>Fe</b>	4 RACE <b>Cau</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>11 25 1893</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D C</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS MONTHS DAYS HOURS MIN	
10 CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wildwood Health Care Center</b>	
12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Server</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Pr &amp; Engr</b>	
13a STATE <b>Virginia</b>		13b COUNTY <b>Fairfax</b>	
13c CITY OR TOWN <b>Alexandria</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e STREET ADDRESS <b>6302 Virginia Hills Ave 22310</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>William Watson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sophia Brandt</b>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b SOCIAL SECURITY NO. <b>577 28 6961</b>	
17 INFORMANT <b>Dau - Evelyn M Donaldson, same as deceased</b>		ADDRESS	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY <b>4339</b> IMMEDIATE CAUSE (a) <b>Terminal cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12/18/75</b> 19____, to <b>1/18/77</b> 19____, that (I) (we) last saw the deceased alive on <b>1/14/77</b> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>[Signature]</i>		22c. DATE SIGNED <b>1/18/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>OSOTH LERAGUL MD</b>		22e. ADDRESS <b>8218 Wisconsin Ave. Bethesda MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1/21/77</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Congressional</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D C</b>	
24. FUNERAL DIRECTOR NAME <i>[Signature]</i>		25a. DATE REC'D. BY REGISTRAR <b>JAN 24 1977</b>	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

X  
X  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

11-2212



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]*

Washington, D.C. 20540  
11/11/77

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02277

1. DECEASED NAME (TYPE OR PRINT) <b>SARAH FELIX SULLIVAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan 23 1977</b>			2b. HOUR <b>7<sup>20</sup> P M</b>				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 17, 1888</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.				
10. CITY OR TOWN OF DEATH <b>OLNEY</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BROOK GROVE NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager Telephone Office</b>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Olney</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Pius Felix</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Urbana Webb</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>220-05-0222A</b>		17. INFORMANT ADDRESS <b>Colombia, Md. 21044</b> <b>Sally Byrnes 10911 Swansfield Rd.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary insufficiency</b> 4/123 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> (c) <b>Generalized arteriosclerosis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Advanced senility &amp; weakness</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4-22-74</b> to <b>1-23-77</b> , that (I) (we) lost saw the deceased alive on <b>11-30-76</b> 19 <b>74</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.										
22b. SIGNATURE <b>John R. Spencer MD</b>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1-24-77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John R. Spencer M. D.</b>			22e. ADDRESS <b>337 Compton Ave, Laurel, Md 20810</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Jan 26, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Emmitsburg, Frederick, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Clarence E. Wilson</b>			ADDRESS <b>Emmitsburg, Md.</b>			25a. DATE <b>JAN 31 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robert H. Brady</b>		

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RECEIVED  
JAN 10 1964

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 77-02278	
1. DECEASED NAME (TYPE OR PRINT) <b>A. Burks SUMMERS</b>						2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> <b>1-19-1977</b>		2b. HOUR <b>6:15 P.M.</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>7/</b> DAY <b>27/</b> YEAR <b>1898</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>78</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	2c. DATE PRONOUNCED DEAD <b>Jan 19 1977</b>		2d. HOUR <b>6:50 P.M.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6520 Tilden Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. Ambassador</b>		12b. KIND OF BUSINESS <b>Foreign Service</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6520 Tilden Lane</b>			
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>W.</b> LAST <b>Summers</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Jennie</b> MIDDLE <b>Burks</b> LAST <b>Burks</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>578-03-4149</b>		17. INFORMANT ADDRESS <b>2101 Conn. Ave. NW</b> <b>Paul D. Summers (Bro)</b> <b>Washington, D.C.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John G. Ball</b>		TITLE (SPECIFY) M.D. <b>Deputy</b>		MEDICAL EXAMINER		DATE SIGNED <b>1/20/77</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>John G. Ball</b>		ADDRESS <b>7936 Old Georgetown Rd. Bethesda, Md</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/21/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>					
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b> ADDRESS <b>5130 Wis. Ave. N.W. Wash., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 25 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>					



11-02-113





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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 77-02279	
1. FOR STATE REGISTRAR					
1. DECEASED NAME (TYPE OR PRINT) <b>Ella Mae Suthard</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>1 29 77</b> 2b. HOUR <b>12:05 A</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>CAU.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>12 - 8 - 06</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70 YRS</b> IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FAIRLAND NURSING HOME</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONT. COUNTY MD.</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
13a. STATE <b>VA</b> 13b. COUNTY <b>ALEXANDRIA</b> 13c. CITY OR TOWN <b>VA</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <b>223 Tenn Ave</b>	
14. FATHER'S NAME <b>Phoenix Love</b>				15. MOTHER'S MAIDEN NAME <b>Fannie Rainey</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>224-92-5257</b>				17. INFORMANT <b>Mary Ann Suthard</b> ADDRESS <b>415-C E. Bellefonte Ave. Alexandria, Va.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ORGANIC BRAIN SYNDROME</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIOVASCULAR ACCIDENT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROSIS</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>2 yrs</b> <b>may yr.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/27</b> , 19 <b>76</b> , to <b>1/29</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>1/17</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Thos G. Ward M.D.</b> DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>1/27/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thos G. WARD</b>				22e. ADDRESS <b>6116 Robinson, Bethesda 20838</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/1/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>	
23d. LOCATION CITY OR TOWN <b>Alexandria, Virginia</b>		23e. COUNTY STATE			
24. FUNERAL DIRECTOR NAME <b>Walter Hall</b> <b>Cunningham Funeral Home, Inc. Alex., Va.</b>				24b. DATE REC'D. BY REGISTRAR <b>FEB 3 1977</b> 24c. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>	

BP



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 (VRA 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		77-02280 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Harry D. Sutton								1-8-77	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
Male		White		Sept. 15, 1894		82		1:10 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York		U.S.A.				Montgomery		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Bel-Pre Health Center				Ret. Dist. Magr. Oil Co.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Mont.		Silver Spring		X NO <input type="checkbox"/>		3623-Gleneagles Drive	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
David M. Sutton		Marie - DeWitt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		068-09-7045		5226-Hermit Path, Columbia, Md. Marshall O. Sutton-son 21054					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) Peripheral Circulatory Collapse							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
H124		DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic CV Disease							2 wk
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (c)							yrt
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
Parkinsonism - mild									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
		P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
				20 11/8 77					
22a. I certify that (I) (this hospital) attended the deceased from 12/12/77 to 1/8/77, that (I) (we) lost saw the deceased alive on 12/12/77, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above. (If (we) did not see the body after death.)									
22b. SIGNATURE		DEGREE				22c. DATE SIGNED			
18111 P. Philip Dr. Chang		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				1/8/77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
18111 P. Philip Dr. Chang		18111 P. Philip Dr. Chang							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		1-13-1977		Lloyd Cemetery		Highland, New York			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Lee Fun. Home 300-4th St., NE, Wash, D.C. 20002		JAN 13 1977				T. McCreedy			

7-52200

White  
New York  
Sept. 12, 1944  
X

Active Spring Half-Year Health Report  
X

Can-00-7045 Marshall O. Burton-son  
5228-10000  
No

1-10-1977  
New York  
1907

Cleared with Md. Exam reg 1  
DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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3601 BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02281	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDWARD N TAMMARO						January 12, 1977				8:55 a.m.	
3. SEX Male		4. RACE Caucas		5. DATE OF BIRTH MONTH DAY YEAR July 6, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) GATEMAN		12b. KIND OF BUSINESS OR INDUSTRY RAILROAD			
13a. STATE Maryland						13b. COUNTY Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST LUIGI TAMMARO						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AMELIA SEIFRET					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 577-03-9809		17. INFORMANT BROTHER ADDRESS WASH., D.C. WILLIAM TAMMARO, 5133 MacARTHUR BOULEVARD					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-PULMONARY ARREST</u> 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>RECURRENT ACUTE MYOCARDIAL INFARCTION</u> (c) <u>SEVERE CORONARY ATHEROSCLEROSIS</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS. 1 HOUR YEARS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>76</u> , to <u>JAN 12</u> , 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>12/7</u> , 19 <u>76</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.											
22b. SIGNATURE Harold W. Draper M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/12/77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD W. DRAPER M.D.						22e. ADDRESS 9801 GEORGIA AVE, Silver Spring, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/15/77		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR JAN 17 1977		25b. REGISTRAR'S SIGNATURE [Signature]			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901											

## BURIAL

53

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02282

1 DECEASED NAME (TYPE OR PRINT) <b>Ethel Elizabeth Taylor</b>			2a DATE OF DEATH MONTH DAY YEAR <b>1-12-77</b>			2b HOUR <b>3:40 AM</b>			
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>11-16-94</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>81</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Va.</b>		7b CITIZEN OF WHAT COUNTRY? <b>American</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a STATE <b>Md.</b>		13b COUNTY <b>Montgomery</b>		13c CITY OR TOWN <b>Silver Spring</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>Ap. 203 8625 Piney Branch Road.</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Richard Allison</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Julia Hamback</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-03-2934</b>		17 INFORMANT ADDRESS <b>Bernard F. Taylor, Silver Spring, Md.</b>					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive cerebral vascular accident</u> <b>4369</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) (this hospital) attended the deceased from <u>1-11</u> , 19 <u>77</u> , to <u>1-12</u> , 19 <u>77</u> , that (1) (we) lost saw the deceased <u>above</u> <u>1-12</u> , 19 <u>77</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above (b) we <u>did not</u> view the body after death.									
22b SIGNATURE <b>Norman S. Kouac MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>1-12-77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>NORMAN S. KOUAC MD</b>				22e. ADDRESS <b>8750 GEORGETOWN BLVD SILVER SPRING MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>1-17-77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Warrenton Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Warrenton, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Arlington</b>				ADDRESS <b>3901 N. Fairfax Dr. Arlington, Va.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Robert H. [Signature]</b>	

course life

• 1947, 1948, 1949, 1950, 1951, 1952, 1953, 1954, 1955, 1956, 1957, 1958, 1959, 1960, 1961, 1962, 1963, 1964, 1965, 1966, 1967, 1968, 1969, 1970, 1971, 1972, 1973, 1974, 1975, 1976, 1977, 1978, 1979, 1980, 1981, 1982, 1983, 1984, 1985, 1986, 1987, 1988, 1989, 1990, 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628,

[illegible]

55-21-1

## Index



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02283				
1. FOR STATE REGISTRAR					1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CATHERINE J. TETO</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>1 15 77</b>			2b. HOUR <b>5<sup>30</sup> A M</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 21 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>								
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13a. STATE <b>MD.</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>12707 ROBINDALE DRIVE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>VINCENT CORDARO</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANGELA MIDIRI</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>RAFFAELA F. ROMANO SAME AS 13 DAUGHTER</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>2509</b> IMMEDIATE CAUSE (a) <b>Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetic Nephropathy</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>weeks</b> <b>YRS</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Congestive Heart Failure, Cerebral Arteriosclerosis</b>														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> 19 <b>76</b> to <b>1/15</b> 19 <b>77</b> , that (I) (we) lost <b>saw</b> the deceased alive on <b>1/14</b> 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>R.T. Benack</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>1/15/77</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.T. BENACK MD</b>				22e. ADDRESS <b>4115 Colie Dr. Wheaton Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>1/17/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>				
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1977</b>				REGISTRAR'S SIGNATURE <b>Kirby McCreedy</b>				

1-12333

(M)

DATE OF BIRTH: 10/10/1910  
PLACE OF BIRTH: [illegible]  
MARRIAGE: [illegible]  
EDUCATION: [illegible]  
OCCUPATION: [illegible]  
MILITARY SERVICE: [illegible]  
REMARKS: [illegible]

NAME: [illegible] SURNAME: [illegible]

DATE OF BIRTH: 10/10/1910

DATE OF BIRTH: 10/10/1910  
PLACE OF BIRTH: [illegible]  
MARRIAGE: [illegible]  
EDUCATION: [illegible]  
OCCUPATION: [illegible]  
MILITARY SERVICE: [illegible]  
REMARKS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02284		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR	
Ethel Farguhar Thomas						1 20 77			10		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		white		MONTH DAY YEAR		91			MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		U.S.A.				Montgomery					MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
90 OLney		Sharon Nursing Home				housewife						
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
35 md.		Mont.		Sandy Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		Box 3				
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME								
150 Allan Farguhar				Charlotte Pleasant								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			
1				218-18-9978								
18. CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
5699 IMMEDIATE CAUSE (a) Cardiovascular failure												
DUE TO OR AS A CONSEQUENCE OF (b) 37 years												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 2 Chronic pyelonephritis												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTORSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
				HOUR A.M. MONTH DAY YEAR								
				P.M. 19								
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION						
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>						STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19 65 to Jan. 20 19 77, that (I) (we) last saw the deceased alive on 12/29/77 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did, (did not) view the body after death.)												
22b. SIGNATURE				DEGREE				22c. DATE SIGNED				
								1/20/77				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS								
C. H. Lyon MD				1811 P. Phillips Rd Olney Md 20832								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE		
				1/24/77		Univ. of Md.		Balt.		Md.		
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
Anatomy Board						1 JAN 26 1977		Anthony McBrady				

10.8.1

10.8.1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		77-02285							
1 DECEASED NAME (TYPE OR PRINT) Ann A. Thompson					2a DATE OF DEATH January 20, 1977			2b HOUR 7 M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH April 19, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 56 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10 CITY OR TOWN OF DEATH Spencerville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 16600 Batson Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Dis.		12b KIND OF BUSINESS OR INDUSTRY Wards Retail	
13a STATE Maryland		13b COUNTY Baltimore		13c CITY OR TOWN Catonsville		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 916 Kent Ave. 21228	
14 FATHER'S NAME Lars				15 MOTHER'S MAIDEN NAME Anna Kneis		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			
16b SOCIAL SECURITY NO. 214-18-8662				17 INFORMANT ADDRESS Md. 20868 Merrill Wick, 16600 Batson Road, Spencerville					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 174X IMMEDIATE CAUSE (a): <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from <u>1/18</u> 19 <u>77</u> , to <u>1/20</u> 19 <u>77</u> , that (1) (we) lost saw the deceased alive on <u>1/18</u> 19 <u>77</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Dr. Raymond Bahr</u>		22c DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d DATE SIGNED <u>1/20/77</u>					
22e PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Raymond Bahr		22f ADDRESS Wilkins & Pine Heights Aves., Balto., Md. 21229							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1-24-77		23c NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Md.			
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home Inc 4107 Wilkens Ave 21229				25a DATE RECD. BY REGISTRAR JAN 21 1977		25b REGISTRAR'S SIGNATURE <u>Robert McCready</u>			

17-02502



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)		2b. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
FIRST MIDDLE LAST		2b. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
CLARA M. Thompson		1/4/77				6:35 A M			
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
Female	CAUCASIAN	3 28 89	87 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				MD.		
IOWA	U. S. A.		Montgomery						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Silver Spring	Bel Pre Health Center		Homemaker		Home				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Montgomery		Silver Spring				14652 Kelmscot Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Son ADDRESS	
Ebenezer Merrick		Lillie May Viers		No		220-46-8933		Md. 20014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a):		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a):		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a):		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a):		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a):	
1719		Fibrosarcoma, metastatic		Sgt-75					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b):		DUE TO, OR AS A CONSEQUENCE OF (c):					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I (this hospital) attended the deceased from 5/12, 1976, to 1/4, 1977, that (I) (we) last saw the deceased alive on 1/4, 1977, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		John G. Lodme, M.D.		MD		1/4/77			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
John G. Lodme, M.D.		18111 Prince Philip Dr., Olney, Md. 20832		Burial		11/7/1977		Parklawn Memorial Park	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		23d. LOCATION CITY OR TOWN COUNTY STATE			
JGS GAWERS SONS		JAN 18 1977		Ritney McCreedy		Rockville, Maryland			
ADDRESS		5730 WISCONSIN AVE. NW.							



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) <b>Joe V. Tine</b>				2b. DATE OF DEATH <b>January 28, 1977</b>		2c. HOUR <b>4:00P</b>	
3. SEX <b>Male</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>March 3, 1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Alabama</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>			
10. CITY OR TOWN OF DEATH <b>Wheaton, Maryland</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>12024 Viers Mill Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Electrician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Wheaton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>12024 Viers Mill Road</b>	
14. FATHER'S NAME <b>John Tine</b>				15. MOTHER'S MAIDEN NAME <b>Mary Burkett</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>578 10 5529</b>		17. INFORMANT ADDRESS <b>B. Etoile Tine (same as 13-e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b> 1621 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) DOE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET <b>12024 Viers Mill Rd</b>		CITY OR TOWN <b>Wheaton</b>		COUNTY <b>Montgomery</b>	
22a. I certify that <b>Dr. John S. Saia</b> attended the deceased from <b>Jan 26</b> , 19 <b>77</b> , to <b>Jan 28</b> , 19 <b>77</b> , that (1) <del>one</del> lost saw the deceased alive on <b>Jan 26</b> , 19 <b>77</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>He</del> (we) <del>did</del> (did not) view the body after death.									
22b. SIGNATURE <b>John S. Saia</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>1/29/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John S. SAIA, MD</b>				22e. ADDRESS <b>809 Viers Mill Rd, Rock MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/1/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Highland Mem Gdns.</b>		23d. LOCATION CITY OR TOWN <b>Bessemer</b>		COUNTY <b>Alabama</b>	
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler F.H. Rockville, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Patrick McCready</b>			

529:4

551, 62, 70082

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6-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02288

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
CARL M TOEPFER		1/22/77		5:40 AM	
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male	W	8 9 '03	73 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH		
Wash. DC	U.S.A.		MONTGOMERY MD.		
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Silver Spring	HOLY CROSS HOSPITAL		estimator		construction
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS
md.		Montgomery	Rockville	YES <input type="checkbox"/> NO <input type="checkbox"/>	14316 Blackmon Drive
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Charles Toepfer		Catherine Graff			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT ADDRESS	
NO		579-01-6444		Elizabeth Pellar, Rockville, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4109 Cardiac arrest					8 hrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					5 da.
DUE TO, OR AS A CONSEQUENCE OF					8 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 1/16/77, 19 to 1/22/77, 19, that (1) (we) last saw the deceased alive on 1/21/77, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.		22b. SIGNATURE DEGREE		22c. DATE SIGNED	
Bernard J. Walsh Sr. M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/22/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Bernard J. Walsh		1800 Eye St NW - 2C			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	01-25-77	Gate of Heaven	Silver Spring, Mont., Md.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hines / Rinaldi Funeral Home		JAN 27 1977		T. J. McCready	

88550-77

RECEIVED - 10/10/77

10/10/77

TO: DIRECTOR, FBI (100-442854) FROM: SAC, NEW YORK (100-100000) (P)

SUBJECT: JAMES EARL RAY, AKA; MURDER OF MARTIN LUTHER KING, JR.; CIVIL RIGHTS

RE: NEW YORK TELETYPE TO BUREAU, OCTOBER NINE, SEVEN SEVEN.

FOR INFORMATION OF THE BUREAU, THE FOLLOWING IS A SUMMARY OF THE

INTERVIEW OF JAMES EARL RAY, CONDUCTED BY NEW YORK OFFICE, OCTOBER

NINE, SEVEN SEVEN. RAY STATED THAT HE HAD BEEN IN NEW YORK CITY

ON OCTOBER EIGHT, SEVEN SEVEN, AND HAD BEEN IN CONTACT WITH

SEVERAL INDIVIDUALS WHO WERE ASSOCIATED WITH THE BLACK PANTHER PARTY

(BPP). RAY STATED THAT HE HAD BEEN INFORMED THAT THE BPP WERE

PLANNING TO HOLD A RALLY IN NEW YORK CITY ON OCTOBER NINE, SEVEN

SEVEN. RAY STATED THAT HE HAD BEEN INFORMED THAT THE RALLY WOULD

BE HELD AT THE NEW YORK CITY MALL, AND THAT HE HAD BEEN INFORMED

THAT THE RALLY WOULD BE HELD AT THE NEW YORK CITY MALL, AND THAT

HE HAD BEEN INFORMED THAT THE RALLY WOULD BE HELD AT THE NEW YORK

CITY MALL, AND THAT HE HAD BEEN INFORMED THAT THE RALLY WOULD BE

HELD AT THE NEW YORK CITY MALL, AND THAT HE HAD BEEN INFORMED THAT

THE RALLY WOULD BE HELD AT THE NEW YORK CITY MALL, AND THAT HE

HAD BEEN INFORMED THAT THE RALLY WOULD BE HELD AT THE NEW YORK CITY

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02289

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>William A. Togashi</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Jan. 15 77</b>			2b. HOUR <b>5<sup>25</sup> PM</b>				
3 SEX <b>male</b>		4 RACE <b>Oriental</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Aug. 21, 1918</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Librarian-Nat. Library of</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Medicine</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Sil. Spg.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3959-Wendy Court</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Bunjiro - Togashi</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Haruyo - Shimizu</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>578-54-4688</b>		17 INFORMANT ADDRESS <b>Haruyo H. Togashi-wife Same as # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>4109</b> IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic vascular disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs</b> 6 days										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>1/13</b> , 19 <b>77</b> , to <b>1/15</b> , 19 <b>77</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>1/15/77</b> , 19 <b>77</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(not)</del> view the body after death.										
22b. SIGNATURE <b>Ronald Landman MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/15/77</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ronald Landman MD</b>			22e. ADDRESS <b>1106 Spring St. Silver Spring Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>1-17-1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>Lee Fun. Home</b>			ADDRESS <b>300-4th St., NE, Wash., D.C.</b>			25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Harvey McCreedy</b>		

MEDICAL CERTIFICATION

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Pages 1-3 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1-3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## Index

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1-17-1977



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		77-02290	
1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE Charles Trevorrow, Sr.		2. DATE OF DEATH MONTH DAY YEAR HOUR Jan 26/77 9:15 P.M.	
3 SEX Male	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8 3 01	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10 CITY OR TOWN OF DEATH Bethesda Md.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CTY. MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer	
13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5941 Avon Dr.	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Trevorrow		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzie Blough	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 208-01-6258-A	
17. INFORMANT ADDRESS Alice M. Trevorrow (Same as 13e),			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 2079 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) CHRONIC LUNG DISEASE (c) LEUKEMIA, INFECTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WRS WR	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) ARTERIOSCLEROTIC HEART DISEASE			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1/26/77 to 1/26/77, that (I) (we) lost the deceased alive on 1/26/77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Daniel Rosenblum		22c. DATE SIGNED 1/26/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL ROSENBLUM		22e. ADDRESS 10400 CONNECT AV, KENSINGTON, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 1-31-77	
23c. NAME OF CEMETERY OR CREMATORY Jefferson Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Pittsburgh Pa.	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Md.		25a. DATE REC'D. BY REGISTRAR JAN 31 1977	
25b. REGISTRAR'S SIGNATURE Anthony McCreedy			

2017/10/26 2017/10/26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02291  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ERMA M. Venable			2a. DATE OF DEATH MONTH DAY YEAR Jan. 23, 1977			2b. HOUR 8:00 A.M.				
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC 6, 1897		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, DC		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Colonial Villa Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1121 UNIVERSITY BLVD., WEST	
14. FATHER'S NAME FIRST MIDDLE LAST MARQUIS L. COLLARD			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CLARA WISH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 211-09-7291		17. INFORMANT SON ADDRESS SILVER SPRING, MD. DAVID C. VENABLE 1001 DOWNS DRIVE,					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Coroner 1579 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Coroner victim of lung-lung (c) Ca of pancreas								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (this hospital) attended the deceased from Nov. 24 1977 to 1/23 1977, that (I) (we) last saw the deceased alive on 1/23/77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
23a. SIGNATURE Michael A. Rodriguez M.D.						DEGREE M.D.		23b. DATE SIGNED Jan. 23/77		
23c. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. RODRIGUEZ						23d. ADDRESS 8634 Flower Ave. T. Park Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 1/25/77		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PRI GEO MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										
25a. DATE REC'D. BY REGISTRAR JAN 26 1977						25b. REGISTRAR'S SIGNATURE R. H. McCreary				

11-02291

UNITED STATES

DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C. 20535

TO :

FROM :

SUBJECT :

RE :

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 11-17-2001 BY 60322 JAL/STP

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH77-02292  
REC. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Warren Milton Walker								1 26 19 77		1		26		77		755	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	white	1/21/26		51 YRS.						1 26 77		1		26		77	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH									
Wash. D.C.		U.S.A.		WIDOWED		DIVORCED		Monterey MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Tale Park		Wash. Adventist Hosp.		CIA Transportation Officer													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md		Prince Georges		Adelphi		YES		1909 Dana Drive									
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST							
Eugene		M.		Walker		Edith		M.		Berkheimer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		215-26-2921		Marie H. Walker		Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
402X		Acute Myocardial Dis															
		(b)		Hypertension		DUE TO, OR AS A CONSEQUENCE OF											
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO									
None		None		YES		NO											
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY		21f. LOCATION		CITY OR TOWN		COUNTY		STATE							
NOT WHILE AT WORK		(AT HOME, STREET, FACTORY, FARM, ETC.)		STREET													
22a. I certify that I took charge of the remains described above, held an		Autopsy		Inspection		Inquiry		and in my opinion									
death resulted from:		Natural causes		Accident		Suicide		Homicide		Undetermined manner							
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		MEDICAL EXAMINER											
Francis J. Collins		M.D.		Jan 26/1977		P.G.											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Francis J. Collins		Silver Spring, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE							
Burial		1-29-77		George Washington		Adelphi		P.G.		Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Francis J. Collins		500 Univ. Blvd. W.		FEB 3 1977		Anthony McCreedy											

13-00000





FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02293

REG NO

1. DECEASED NAME (TYPE OR PRINT) <b>Florence Rita Walsh</b>			2a. DATE OF DEATH MONTH <b>1</b> / DAY <b>30</b> / YEAR <b>77</b>		2b. HOUR <b>6:37 AM</b>		
3 SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH <b>5</b> / DAY <b>13</b> / YEAR <b>01</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS. MONTHS <b>0</b> / DAYS <b>0</b> / HOURS <b>0</b> / MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10 CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac Valley Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Montgomery</b> 13c CITY OR TOWN <b>Rockville</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>13204 Twinnbrook Parkway</b>	
14 FATHER'S NAME FIRST <b>Edward</b> MIDDLE <b>Walsh</b> LAST <b>See</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Teresa</b> MIDDLE <b>See</b> LAST <b>See</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>188-32-6315</b>		17. INFORMANT <b>802 Twinnbrook Parkway</b> <b>Vivienne Dougherty, Rockville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized atherosclerosis</b> <b>4369</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: DOUE TO, OR AS A CONSEQUENCE OF (b) _____ DOUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Stroke</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the undersigned) attended the deceased from <b>1/17/77</b> , 19 <b>75</b> , to <b>1/30/77</b> , 19 <b>77</b> , that (we) lost saw the deceased alive on <b>1/11/77</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Horace W. Bernton</b> (STEVEN JONES)				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/30/77</b>	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Horace W. Bernton, M.D.</b>				22e. ADDRESS <b>4743 Bradley Blvd., Chevy Chase, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/3/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Hanover Township</b> COUNTY <b>Penna</b> STATE	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey</b>				25a. DATE REC'D. BY REGISTRAR <b>FEB 3 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCreedy</b>	
24. FUNERAL DIRECTOR <b>7557 Wisconsin Ave., Bethesda, Md.</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

17-02203



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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

77-02294  
REG. NO.

**1- FOR  
STATE  
REGISTRAR**

<b>1. DECEASED NAME</b> (TYPE OR PRINT)			<b>FIRST</b>			<b>MIDDLE</b>			<b>LAST</b>			<b>2a. DATE KNOWN OF DEATH</b> ESTIMATED <input checked="" type="checkbox"/> 1 10 19 77			<b>2b. HOUR</b> 12 54 PM				
LOMAX						WAMSLEY, JR.													
<b>3. SEX</b> Male		<b>4. RACE</b> W		<b>5. DATE OF BIRTH</b> MONTH DAY YEAR 9-29-16		<b>6. AGE (IN YEARS)</b> (LAST BIRTHDAY) 60 YRS.		<b>IF UNDER 1 YR.</b> MONTHS DAYS		<b>IF UNDER 24 HRS.</b> HOURS MIN		<b>2c. DATE PRONOUNCED DEAD</b> Jan. 10 1977			<b>2d. HOUR</b> 12 54 PM				
<b>7a. BIRTHPLACE</b> (STATE OR FOREIGN COUNTRY) W. Va.				<b>7b. CITIZEN OF WHAT COUNTRY?</b> USA				<b>8. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				<b>9. BALTIMORE CITY OR COUNTY OF DEATH</b> Montgomery MD.							
<b>10. CITY OR TOWN OF DEATH</b> Bethesda				<b>11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION</b> (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban						<b>12a. USUAL OCCUPATION</b> (TYPE OF WORK FOR MOST OF WORKING LIFE) Parts Inspector				<b>12b. KIND OF BUSINESS OR INDUSTRY</b> Defense Dept					
<b>USUAL RESIDENCE</b> (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																			
<b>13a. STATE</b> Md.				<b>13b. COUNTY</b> Montgomery				<b>13c. CITY OR TOWN</b> Potomac				<b>13d. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>13e. STREET ADDRESS</b> 10909 Gainsborough Rd.					
<b>14. FATHER'S NAME</b> FIRST MIDDLE LAST Lomax Wamsley, Sr.								<b>15. MOTHER'S MAIDEN NAME</b> FIRST MIDDLE LAST Mary Minear											
<b>16a. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (YES, NO, OR UNKNOWN) Yes				<b>(IF YES, GIVE WAR OR DATES)</b> WW II				<b>16b. SOCIAL SECURITY NO.</b> 217-14-7337				<b>17. INFORMANT</b> Dorothy M. Wamsley				<b>ADDRESS</b> Same as 13			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u> 4119 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF														<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>					
<b>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).</b>																			
<b>19a. DATE OF OPERATION</b>				<b>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</b>												<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. EXTERNAL CAUSE WAS</b> UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				<b>21b. TIME OF INJURY</b> HOUR A.M. MONTH DAY YEAR P.M. 19				<b>21c. HOW INJURY OCCURRED</b> (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
<b>21d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				<b>21e. PLACE OF INJURY</b> (AT HOME, STREET, FACTORY, FARM, ETC.)				<b>21f. LOCATION</b> STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
<b>ACTUAL SIGNATURE</b> <i>John G. Ball</i>								<b>TITLE (SPECIFY)</b> M.D. Deputy				<b>MEDICAL EXAMINER</b>				<b>DATE SIGNED</b> Jan. 10, 1977			
<b>EXAMINER'S NAME</b> (TYPE OR PRINT) John G. Ball								<b>ADDRESS</b> Bethesda, Maryland											
<b>23a. BURIAL, CREMATION, REMOVAL</b> (SPECIFY) Burial				<b>23b. DATE</b> Jan. 13, 1977				<b>23c. NAME OF CEMETERY OR CREMATORY</b> Chestnut Grove Cem.				<b>23d. LOCATION</b> CITY OR TOWN COUNTY STATE Herndon, Va.							
<b>24. FUNERAL DIRECTOR</b> NAME Homes, P.A.								<b>ADDRESS</b> Bethesda, Md.				<b>25a. DATE RECEIVED BY REGISTRAR</b> JAN 17 1977				<b>25b. REGISTRAR'S SIGNATURE</b> <i>Henry McCready</i>			

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORMS 1, 2, AND 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201



*John*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		77-02295 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Merhle Basil WARFIELD, Sr.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>1/25/77</b>		2b. HOUR <b>5:00 P.M.</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 11, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8101 Damascus Rd.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Gaithersburg</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Basil T. Warfield</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice F. Mullinix</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>219-36-9603</b>		17. INFORMANT ADDRESS <b>7301 Damascus Rd. Gaithersburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>15 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 13</b> , 19 <b>77</b> , to <b>Jan 22</b> , 19 <b>77</b> , that (I) (we) lost saw the deceased alive on <b>Jan 13</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>A. D. Bonifant</b>				22c. DATE SIGNED <b>1/26/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. D. BONIFANT</b>				22e. ADDRESS <b>OHNEY Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan. 27, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Damascus, Montgomery, Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Olin L. Molesworth, Damascus, Md.</b>			
25a. DATE REC'D. BY REGISTRAR <b>JAN 28 1977</b>				25b. REGISTRAR'S SIGNATURE <b>Barbara McCready</b>	

MEDICAL CERTIFICATION

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

77-02296  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Milton A. Warren			2a. DATE KNOWN OF DEATH 1-21-1977			2b. HOUR 6:50 M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH 3 MONTH 15 DAY 1903	6. AGE (IN YEARS) 73 BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD 1-21-1977	2d. HOUR 6:50 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 12414 Denley Rd.			12a. USUAL OCCUPATION (TYPE OF WORK) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Bell Labs	

13a. STATE Md			13b. COUNTY MONTGOMERY	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 12414 Denley Rd.	
14. FATHER'S NAME Milton A. Warren			15. MOTHER'S MAIDEN NAME Elsa Glaser				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 066-09-2856		17. INFORMANT Ruth E. Cipolla		
					ADDRESS Same as #13 Daughter		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion		
ACTUAL SIGNATURE Richard P. W. Helton			TITLE (SPECIFY) M.D. Deputy Medical Examiner		
EXAMINER'S NAME (TYPE OR PRINT) RICHARD L. WHELTON			ADDRESS 7100 Baltimore Ave College Park Md		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 1/25/77	23c. NAME OF CEMETERY OR CREMATORY GREEN WOOD	23d. LOCATION CITY OR TOWN BROOKLYN	COUNTY NEW YORK	STATE
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			25a. DATE REC'D. BY REGISTRAR JAN 26 1977	25b. REGISTRAR'S SIGNATURE Anthony McCready	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

00880-7

RESEARCH AND ANALYSIS  
MEDICAL EXAMINATIONS

UNITED STATES

1. NAME OF SUBJECT: [illegible]  
2. DATE OF EXAMINATION: [illegible]  
3. LOCATION OF EXAMINATION: [illegible]  
4. NAME OF EXAMINER: [illegible]  
5. TITLE OF EXAMINER: [illegible]  
6. PURPOSE OF EXAMINATION: [illegible]  
7. RESULTS OF EXAMINATION: [illegible]  
8. COMMENTS: [illegible]

9. SIGNATURE OF EXAMINER: [illegible]  
10. DATE OF SIGNATURE: [illegible]  
11. SIGNATURE OF SUBJECT: [illegible]  
12. DATE OF SIGNATURE: [illegible]  
13. SIGNATURE OF WITNESS: [illegible]  
14. DATE OF SIGNATURE: [illegible]

15. SIGNATURE OF APPROVING OFFICER: [illegible]  
16. DATE OF SIGNATURE: [illegible]  
17. SIGNATURE OF APPROVING OFFICER: [illegible]  
18. DATE OF SIGNATURE: [illegible]  
19. SIGNATURE OF APPROVING OFFICER: [illegible]  
20. DATE OF SIGNATURE: [illegible]

21. SIGNATURE OF APPROVING OFFICER: [illegible]  
22. DATE OF SIGNATURE: [illegible]  
23. SIGNATURE OF APPROVING OFFICER: [illegible]  
24. DATE OF SIGNATURE: [illegible]  
25. SIGNATURE OF APPROVING OFFICER: [illegible]  
26. DATE OF SIGNATURE: [illegible]

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02297

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>MARTHA L. WARRING</b>			2a DATE OF DEATH MONTH DAY YEAR <b>1-8-77</b>			2b HOUR M <b></b>			
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JUNE 12, 1892</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b></b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D. C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10 CITY OR TOWN OF DEATH <b>KENSINGTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KENSINGTON GARDENS NURSING HOME</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b KIND OF BUSINESS OR INDUSTRY <b></b>	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MD.</b>		13b COUNTY <b>MONTGOMERY</b>		13c CITY OR TOWN <b>ROCKVILLE</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>12114 WHIPPOORWILL LANE</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES DANFORTH</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAURA HOLT</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>578-52-4927</b>		17 INFORMANT <b>MARTHA WARRING</b>		ADDRESS <b>SAME AS 13</b>		DAUGHTER	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Chronic Brain syndrome</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b></b>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec. 26</b> , 19 <b>76</b> to <b>Jan. 8</b> , 19 <b>77</b> , that (I) (we) last saw the deceased alive on <b>Jan. 2</b> , 19 <b>77</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Wilfred R. Ehrmantraut</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>1/19/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wilfred R. Ehrmantraut</b>						22e. ADDRESS <b>11125 Rockville Pike, Rockville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>1/11/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BRENTWOOD PRI GEO MD.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>FRANCIS J. COLLINS</b> <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>						25a. DATE REC'D. BY REGISTRAR <b>JAN 17 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Richard M. Brady</b>	

MEDICAL CERTIFICATION

X  
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

17-02287

17-02287

NO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

17-02298

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST Ernest William Waskey		1/28/77		9 <sup>50</sup> A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	IF UNDER 1 YEAR	
M	W	MONTH DAY YEAR JAN 11 1905	72 YRS	MONTHS	DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND	U.S.A.		MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
TAKOMA PARK	Washington Adventist Hospital	Green house	US Govt		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD	P.G.	Beltsville	YES <input type="checkbox"/> NO <input type="checkbox"/>	Attendant 4620 Garnett Ave	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
FIRST MIDDLE LAST Maurice E. Waskey	FIRST MIDDLE LAST Lillian E. Hartman	NO			
16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
	Robert L. Waskey	4309 34th St Brentwood Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>respiratory arrest</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					2-3 months
DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic small cell carcinoma</u>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	HOUR A.M. MONTH DAY YEAR P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION (CITY OR TOWN COUNTY STATE)			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 27</u> 19 <u>77</u> to <u>Jan 28</u> 19 <u>77</u> , that (I) (we) last saw the deceased alive on <u>Jan 27</u> 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>DJ HAIDAK</u>	MD			1/28/77	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
DJ HAIDAK	6525 Bluest Rd, Hyattsville				
23a. BURIAL, CREMATION, REMOVAL (TYPE)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN COUNTY STATE)		
Burial	Feb 1, 1977	Gray-Wash Cem	Hyattsville Md.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Donaldson Funeral Home		FEB 4 1977		[Signature]	

MEDICAL CERTIFICATION

7402 BP

11-05180



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

#5, per fam. 2/7/77 kam

1. STATE  
FOR ph.call.  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02299  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Eileen R. Waters			2a. DATE OF DEATH MONTH DAY YEAR January 3 1977			2b. HOUR 1217P M			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 5, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Virginia		13b. COUNTY Fairfax		13c. CITY OR TOWN Falls Church		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6928 West Lawn Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Harry				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Keegan					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 405 01 7885		17. INFORMANT ADDRESS Falls Church, Va. Mrs. Peggy Zandler 2840 Wickersham Way					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral necrotizing bronchopneumonia 485x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec. 2, 1976 to Jan. 3, 1977, that (I) (we) last saw the deceased alive on Jan. 3, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE DEGREE Bruce K. Lloyd, M.D.						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Jan. 4, 1977	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Bruce K. Lloyd, M.D.						22e. ADDRESS National Naval Medical Center, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 1/7/77		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington Va.		
24. FUNERAL DIRECTOR NAME Murphy Funeral Home						25a. DATE REC'D. BY REGISTRAR JAN 7 1977		25b. REGISTRAR'S SIGNATURE P. J. McCreedy	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										77-02300			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Louella		D.		Watkins				Jan 8		4778 A		M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTH DAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Female		White		June 14, 1892		84		YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALT. OR COUNTY OF DEATH							
New York		USA				Montgomery						MD	
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Takoma Park		7051 Carroll Ave.		Housewife		Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Montg.		Takoma Park		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		7051 Carroll Ave.					
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
Alfred		Day				Emma		Baum					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS							
No		220-12-3002		Jane Rainey		8506 Wakefield		San Antonio, Texas					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 4121 Cardiac Arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		Months	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Arteriosclerotic Heart Disease										Years			
DUE TO, OR AS A CONSEQUENCE OF													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>													
22a. I certify that (I) (this hospital) attended the deceased from June 1976 to Jan 8, 1977, that (I) (we) lost saw the deceased alive on above (I) (we) (did) (did not) view the body after death.										and that in (my) (our) opinion death occurred on the date and hour and from the causes stated			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
Michael K. Smith, M.D.		M.D.				Jan 77							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Michael K. Smith, M.D.		7600 Carroll Ave		Takoma Park, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		Jan. 11, 1977		Abbington Hills Cem.		Hallstead, Pa.							
24 FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Robert A. Pumphrey		Homes, P.A. Bethesda, Md.		JAN 17 1977		History McCreedy							

77-02300

Investigative Division

San Antonio, Texas

10-1-1961

TO DIRECTOR

FROM

SAC

San Antonio, Texas

10-1-1961

San Antonio, Texas

10-1-1961

10-1-1961

10-1-1961

10-1-1961

10-1-1961

10-1-1961

10-1-1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 77-02301						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Viola H. Watson			2a. DATE OF DEATH MONTH DAY YEAR January 13 1977		2b. HOUR 430 A.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR January 24 1904		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY -	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Pr. George		13c. CITY OR TOWN Clinton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6213 Kaine Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel G. Thompson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Carrick					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 577 09 6372		17. INFORMANT ADDRESS Dale Kepner See item 13			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 3977 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>RHEUMATIC VALVE DISEASE</u> (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>CIRRHOSIS AND ASCITES</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>Jan. 12</u> , 19 <u>77</u> , to <u>Jan. 13</u> , 19 <u>77</u> , that (1) (we) lost saw the deceased alive on <u>Jan. 13</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>GC Boratno</u>				DEGREE <u>LT USNR</u>				22c. DATE SIGNED Jan. 13, 1977	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS National Naval Medical Center, Bethesda, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/15/77		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Pr. George Md.			
24. FUNERAL DIRECTOR NAME Nalley's Funeral Home				ADDRESS Mt. Ranier, Md.		25a. DATE REC'D. BY REGISTRAR JAN 17 1977		25b. REGISTRAR'S SIGNATURE <u>Anthony McCready</u>	



100-10-10  
[Faint, mostly illegible text and markings, possibly a form or document header, including some numbers and lines.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

17-02302

1. DECEASED-NAME (Type or print) First Middle Last <b>ADELAIDE MARIE MORAN WATTS</b>			2a. DATE OF DEATH Jan Month 6 Day 1977 Year		2b. HOUR 15 P. M.
3. SEX <b>Female</b>	4. RACE <b>white</b>		5. DATE OF BIRTH <b>Feb. 27, 1896</b>		6. AGE (in years last birthday) <b>80</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>at home 601 Dale Drive</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House wife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>St Mary's</b>	13c. CITY OR TOWN <b>Avenue</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First Middle Last <b>John Moran</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary Frances Knowles</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>485X</b>		17. INFORMANT <b>Mary Blanco 22N Granada Arlington, Va</b> <b>Katherine Watts daughter 601 Dale Dr., Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>general debility &amp; osteoarthritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 mos.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1977		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 30, 1976</b> , to <b>Jan 6, 1977</b> , that (I) (we) last saw the deceased alive on <b>Jan 6, 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Sydney Leventhal, M.D.</b> DEGREE				22c. DATE SIGNED <b>Jan 6, 1977</b>	
22d. PHYSICIAN'S NAME (Print) <b>Sydney Leventhal, M.D.</b>				22e. ADDRESS <b>Silver Spring, Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Jan 8, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Erin</b>	
23d. LOCATION (City or Town) (County) (State) <b>Havre de Grace, Md.</b>		24. FUNERAL DIRECTOR ADDRESS <b>W. Clarke Mattingley Leonardtown, Maryland</b>		25a. RECORD BY REGISTRAR DATE <b>JAN 12 1977</b>	
25b. REGISTRAR'S SIGNATURE <b>Robert McCready</b>					



17 3302

CERTIFICATE OF DEATH

DD

1900-1900

X

USA

1910

Home

Home

Home

X

Home

Home

Home

Home

10

Home

Home

Home

Home

Home



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02303

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
Frank Pete Wayne			January 27, 1977			6:30A M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR		
Male	White	1 18 20	57			MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH					
Michigan	U.S.A.		Montgomery County MD					
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b USUAL INDUSTRY		
Bethesda	Clinical Center, NIH Beth. Md		Maintenance			Commonwealth Industries		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN		
Michigan			Unknown			Redford Twp.		
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES?		
Felix - Wengzynowicz			Lucy - Grzybowska			Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS		
373-12-4691			Pauline E. Wayne			1539 Woodbine Redford Twp., Michigan		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>1519</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma Of The Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Year</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 3</u> , 19 <u>77</u> , to <u>January 27</u> , 19 <u>77</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 27</u> , 19 <u>77</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.			22b. SIGNATURE <u>Neil M. Ellison MD</u>			22c. DATE SIGNED <u>1/28/77</u>		
22a. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Neil M. Ellison MD</u>			22b. ADDRESS National Institutes of Health, Clinical Center, Bethesda, Md. 20014					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>			23b. DATE <u>1/29/77</u>		23c. NAME OF CEMETERY OR CREMATOR <u>Wilkie Funeral Home</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Detroit Michigan</u>	
24. FUNERAL DIRECTOR NAME <u>Chambers Funeral Home</u>			ADDRESS <u>5801 Cleveland Ave. Riverdale, MD</u>			25a. DATE REC'D. BY REGISTRAR <u>FEB 2 1977</u>		
						25b. REGISTRAR'S SIGNATURE <u>Henry McCready</u>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

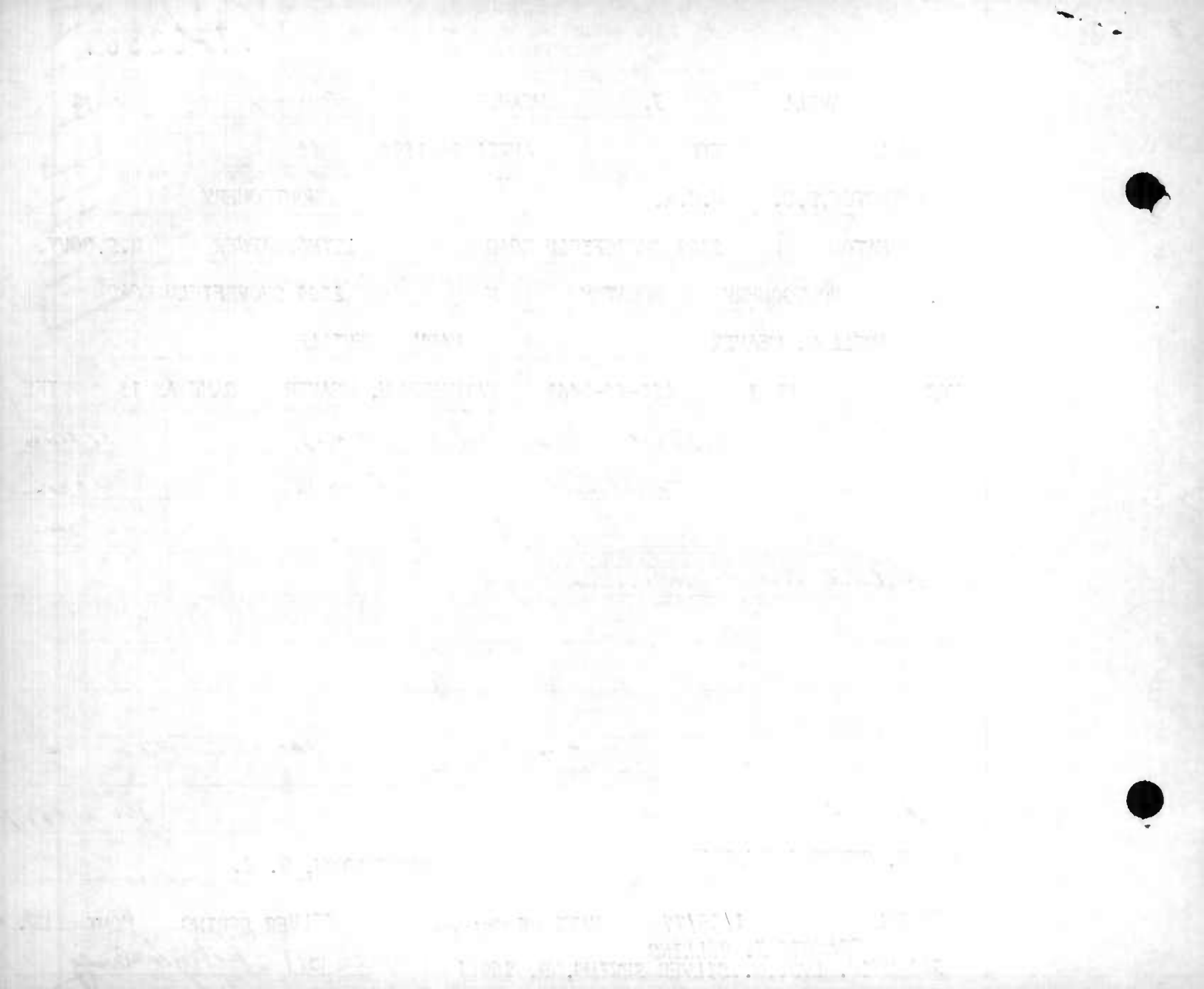
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 77-02304				
1 DECEASED NAME (TYPE OR PRINT) ARELL J. WEAVER				2a. DATE OF DEATH MONTH DAY YEAR January 21, 1977				2b. HOUR 12:15 P.M.				
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR APRIL 24, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.						
10 CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2309 SHOREFIELD ROAD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LITHOGRAPHER		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOVT.				
13a. STATE MD.				13b. COUNTY MONTGOMERY		13c. CITY OR TOWN WHEATON		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2309 SHOREFIELD ROAD		
14. FATHER'S NAME FIRST MIDDLE LAST ARELL W. WEAVER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY NEVILLE								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I		17 INFORMANT KATHLEEN M. WEAVER		ADDRESS SAME AS 13		WIFE				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stroke (Brain Stem Hemorrhage)</u> 4379 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>37 days</u> <u>57 days</u> <u>107 days</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Malnutrition &amp; Anemia</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>May 16</u> , 19 <u>76</u> to <u>Jan 21</u> , 19 <u>77</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>Dec 17</u> , 19 <u>76</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.												
22b. PHYSICIAN'S NAME (TYPE OR PRINT) R. STEPHEN HULBURT				22c. ADDRESS WASHINGTON, D. C.				22d. DATE SIGNED Jan 21, 1977				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/25/77		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR JAN 26 1977				25b. REGISTRAR'S SIGNATURE <i>Henry McCreedy</i>				

3207 BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR	
			FIRST MIDDLE LAST CORA Lee WEBSTER		JAN 22 1977	
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		2b. HOUR
Female		Caucasian		9 18 1886		8 <sup>35</sup> A.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS
Wash. D. C.		U. S. A.		90 YRS.		IF UNDER 24 HRS. HOURS MIN.
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.
Bethesda		Suburban Hosp		Montgomery		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Clerk			Vet. Admin.			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN	
Maryland			Montgomery		Chevy Chase	
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
William Henry Troxell			Rosa Gertrude Lynch		3515 Raymond Street	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS	
No			578-09-9678		6949 Elizabeth Rosemary Macdonald, McLean, Va. Dr.	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 CONJECTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC VASCULAR DISEASE MANY YEARS DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 HRS.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1/21/77 to 1/22/77, that (I) (we) lost saw the deceased alive on 1/21/77, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE S. RALPH HIMMELTUCH, MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 1/22/77
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS		
S. RALPH HIMMELTUCH, MD				50 W. EDMONSTON DR. ROCKVILLE, MD		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE
Burial		1-25-77		Gate of Heaven Cem.		Silver Spring, Maryland
24 FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
				JAN 26 1977		Robert A. Pumphrey

77-02305

5200 BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 17-02306	
1- STATE REGISTRAR		2a. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Jerome Weiler						2b. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-9 1977		2c. HOUR OF DEATH 7:00 PM	
3. SEX M.	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 9-8 1914	6. AGE (IN YEARS) LAST BIRTHDAY 62 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD Jan 9 1977		2d. HOUR OF DEATH 7:15 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8206 Thoreau Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8206 Thoreau Dr			
14. FATHER'S NAME FIRST MIDDLE LAST HENRY WEILER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST FLORENCE SACKETT							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. WWII		17. INFORMANT GENEVIEVE WEILER		ADDRESS SAME # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 955X Gun Shot Wound of Head Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Self-Inflicted. (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 7 P.M. 1-9 1977		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Shot self. Shotgun - muzzle in mouth.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home.		21i. LOCATION STREET CITY OR TOWN COUNTY STATE 8206 Thoreau Dr. Bethesda Mont. Md.							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE John B. Bull		TITLE (SPECIFY) M.D. Deputy		MEDICAL EXAMINER				DATE SIGNED Jan 9, 1977			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1-12-77		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATL. CEM.				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington VA.			
24. FUNERAL DIRECTOR NAME John F. DeVol		ADDRESS DE VOL FUNERAL HOME WASH. D.C.		25a. DATE REC'D. BY REGISTRAR JAN 13 1977				25b. REGISTRAR'S SIGNATURE Anthony McCready			

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1- FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>OSBY</b>		FIRST <b>OSBY</b> MIDDLE <b>LEE</b> LAST <b>WEIR</b>		2a. DATE OF DEATH MONTH <b>1</b> DAY <b>6</b> YEAR <b>77</b>		2b. HOUR <b>9:45</b> M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>3</b> DAY <b>24</b> YEAR <b>12</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILLINOIS</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retail-Gen Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Seares</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>George</b> MIDDLE <b>Levi</b> LAST <b>Weir.</b>		15. MOTHER'S MAIDEN NAME FIRST <b>OLLIE</b> MIDDLE <b>Rebecca</b> LAST <b>Reed</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>318-01-8650</b>		17. INFORMANT ADDRESS <b>Wife Frances E. Weir</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Overwhelming pneumonia of left 2 days</b> (b) <b>Renal Failure secondary 1 year</b> (c) <b>to Multiple Myeloma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Erythema Gangrenosum</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (the hospital) attended the deceased from <b>February 68</b> to <b>6 January 77</b> , that (1) (the deceased) died on <b>6 January 77</b> , and that in my opinion death occurred on the date and hour and from the causes stated							
22b. SIGNATURE <b>Michel M. Healy MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/7/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Michel M. HEALY MD</b>		22e. ADDRESS <b>541 W. Cedar Ln, Bethesda MD 20014</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/11/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc. Washington, D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>JAN 13 1977</b>		25b. REGISTRAR'S SIGNATURE <b>William McBrady</b>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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100-10-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02308

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
I. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		3 <sup>45</sup> p.m.	
FIRST MIDDLE LAST Carolyn F. Wheeler		January 20-1977			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	Cauc.	MONTH DAY YEAR 12-3-1900	76	IF UNDER 24 HRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH	
Washington, D.C.		U.S.A.		Montgomery MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Chevy Chase	3205 Thorneapple St.		Homemaker		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
MD.	Montg.	Chevy Chase	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3205 Thorneapple St.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST MIDDLE LAST Robert Lee Faris			FIRST MIDDLE LAST Carrie Hellen		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		Unknown		Dan H. Wheeler (Same as 13e)	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Pancreas</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
Dec. 23, 1976		Laparotomy - Carcinoma of Pancreas		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 11</u> , 19 <u>76</u> , to <u>Jan 20</u> , 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>Jan 18</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE Robert B. Havrell MD		22c. DATE SIGNED Jan. 20, 1977	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Robert B. Havrell MD		5516 Nebraska Ave NW Washington DC			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
BURIAL		1-24-77		Rock Creek Cem.	
23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Washington, D.C.		D.C.		MD.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Humphrey Funeral Homes, P.A., Bethesda, Md.		JAN 26 1977		[Signature]	

MEDICAL CERTIFICATION

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MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. NO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										77-02309 REG. NO.			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ward J. Wilkie										ESTIMATED <input type="checkbox"/> 25-26-77		4:15 PM	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 10 31 28 48 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD Jan 26 19 77		2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery Co.			
10. CITY OR TOWN OF DEATH Sil. Spg.				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Technician				12b. KIND OF BUSINESS <del>XXXXXXXX</del>	
13a. STATE Md.				13b. COUNTY Mont.		13c. CITY OR TOWN Sil. Spg.		13d. INSIDE CITY LIMITS? YES <del>XXXXXX</del>		13e. STREET ADDRESS 2208 Hermitage Ave			
14. FATHER'S NAME FIRST MIDDLE LAST John B. Wilkie				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl W. Wilkie									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE YEAR OR DATES) 1 yes				16b. SOCIAL SECURITY NO. 218-24-2412				17. INFORMANT ADDRESS Katherine M. Wilkie - wife- (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5710 Hepatic Encephalopathy DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Chronic Liver Disease DUE TO, OR AS A CONSEQUENCE OF (c) Alcohol												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). None													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE [Signature]				TITLE (SPECIFY) M.D. Dep				MEDICAL EXAMINER				DATE SIGNED Jan 21, 1977	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, DME				ADDRESS Silver Spring, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Jan. 25, 1977		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Prince Georges Md.			
24a. DATE REC'D. BY REGISTRAR				24b. REGISTRAR'S SIGNATURE [Signature]									

Funeral Director  
Warner E. Pumphrey, Inc.,  
8434 Ga. Ave. & S.S. Md.

24a. DATE REC'D. BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

JAN 27 1977 [Signature]

• 100% Satisfaction Guarantee

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

77-02310

1. FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>MARCIA W. WILKINS</b>			2a DATE OF DEATH MONTH DAY YEAR <b>JANUARY 7, 1977</b>			2b HOUR <b>9:00 AM</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>MAY 3, 1899</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>IDAHO</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY Co. MD.</b>			
10 CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5805 JOHNSON COURT</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>MARYLAND</b>		13b COUNTY <b>MONTGOMERY</b>		13c CITY OR TOWN <b>BETHESDA</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS <b>5805 JOHNSON COURT</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM C. WHITWELL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>NORA - YEARIAN</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b SOCIAL SECURITY NO. <b>486-16-5883</b>		17. INFORMANT ADDRESS <b>MR. FRANKLIN A. WILKINS SAME AS #13.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1579 IMMEDIATE CAUSE (a): Cancer of the pancreas</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b): <b>Hypo Thyroidism</b>									
19a DATE OF OPERATION <b>12/6/76</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ca of pancreas</b>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 2, 1976</b> to <b>Jan. 6, 1977</b> , that (I) (we) lost saw the deceased alive on <b>Jan. 6, 1977</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Thomas L. Hartman M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>Jan. 7, 1977</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>THOMAS L. HARTMAN</b>				22e. ADDRESS <b>3301 NEW MEXICO N.W. D.C.</b>					

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>JAN. 8, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR HILL CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SUITLAND P.G. Co. MD.</b>	
24. FUNERAL DIRECTOR NAME <b>CHAMBERS FUNERAL HOME</b>				ADDRESS <b>RIVERDALE, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 12 1977</b>	
				25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02311

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>JOHN WILLIE</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>JAN 3 1977</b>		2b. HOUR M <b></b>	
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG 16 1904</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>FAIRLAND NURSING HOME CUSTODIAN SCHOOL SYSTEM</b>	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PG CO</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PG CO</b>		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13b. STREET ADDRESS <b>327 THOMAS DRIVE</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY NELSON WILLEY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY ANN EDISON</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>2</b>		16b. SOCIAL SECURITY NO. <b>216-10-1328A</b>		17. INFORMANT ADDRESS <b>8102 KENNY PKY</b> <b>ERNEST L. WILLEY OXON HILL MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 1410 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Metastatic Ca Neck &amp; Skull 8 mos</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Basal Cell Ca (base of Tongue) 18 mos.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Genit Arteriosclerosis</b>			
19a. DATE OF OPERATION <b>12/6/75</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Tumor base of tongue</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21b. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART I OR PART 2)	
21c. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>118/68</b>		21d. LOCATION STREET CITY OR TOWN COUNTY STATE <b>118/68</b>		21e. DATE SIGNED <b>1/12/77</b>	
22a. SIGNATURE <b>J. M. Warren</b>		22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J. M. WARREN</b>		22c. ADDRESS <b></b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Jan 6, 1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lyn Hill</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Burial</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Canachian Funeral Home Md</b>		25. DATE REC'D. BY REGISTRAR <b>JAN 10 1977</b>	
26. REGISTRAR'S SIGNATURE <b>Pirkay McCreedy</b>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use by the funeral director, the death certificate must be filed within 72 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The funeral director must be notified of once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. The funeral director must be notified of once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 77-02312	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Elizebeth Wing</b>						<b>Jan. 16 1977</b>				<b>2 P M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>July 28 1886</b>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <b>90</b> YRS.		IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10 CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5437 Conn. Ave., N.W.</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carl Wilhelm</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Thrig</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>578-42-0378</b>		17. INFORMANT ADDRESS <b>Nephew Frederick Meyer. 94 Highland Pkwy. Rochester New York 14620</b>					
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>174X Carcinoma of breast</b> IMMEDIATE CAUSE (a) <b>Metastasis to lung</b> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <b>Metastasis to lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Metastasis to lung</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b> <b>6 mos</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>Jan. 1 19 40 to Jan 16 19 77</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 17 19 77</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John E. Everett</b>						DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>1/16/77</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John E. Everett, M.D.</b>						22e. ADDRESS <b>9400 Conn. Ave., Kens. Maryland 20003</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>				23b. DATE <b>1/19/1977</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Grove Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Augusta, Maine</b>			
24. FUNERAL DIRECTOR NAME <b>JOSEPH GAWLER'S SONS, INC.</b>						25a. DATE REC'D BY REGISTRAR <b>1/20/77</b>		25b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 77-02312
1. FOR STATE REGISTRAR				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Max Charles Wirtz			2a. DATE OF DEATH MONTH DAY YEAR January 31, 1977	
3. SEX Male		4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR March 14, 1899	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A	6. AGE (IN YEARS LAST BIRTHDAY) YRS 77	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD	
13a. STATE Maryland		13b. COUNTY Mont.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner-Furniture Mfg. Co.	
14. FATHER'S NAME FIRST MIDDLE LAST Carl Wirtz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna E. Harstick		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-32-1149		
17. INFORMANT ADDRESS A-Madge I. Wirtz-Same as items 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive Cerebral Hemorrhage 4319 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cerebral Vascular Disease over 10 yr. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hrs.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
22a. I certify that (I) (this hospital) attended the deceased from 2-20, 1970, to 1-31, 1977, that (I) (we) lost saw the deceased alive on 1-31, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Louis H. Shuman, M.D.		DEGREE M.D.		22c. DATE SIGNED 2-1-77
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis H. Shuman, M.D.		22e. ADDRESS 8750 Georgia Ave., Silver Spring, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/4/77		23c. NAME OF CEMETERY OR CREMATORY Loudon Park
23d. LOCATION CITY OR TOWN Baltimore, Balt., Md.		23e. STATE Md.		
24. FUNERAL DIRECTOR NAME W. W. Chambers Co., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR FEB 7 1977		25b. REGISTRAR'S SIGNATURE Henry McCready

01-000-11



1- STATE REGISTRAR

REG NO. 02214

1. DECEASED NAME (TYPE OR PRINT) <b>Jackson Ward Wisner, Sr.</b>		LAST		20. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>1 13 19 77</b>		2b. HOUR <b>2:20 P. M.</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov 20, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS <b>76</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U*S*A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co.</b>	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. BUSINESS OR INDUSTRY <b>Merchant Teacher</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Ward Wisner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Roseberry</b>		13e. STREET ADDRESS <b>Whisperwill Lane</b>		13f. ADDRESS <b>706 Twinbrook Pkwy. Rockville, Maryland</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>William M. Wisner</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>Arteriosclerotic cardiovascular disease</b> IMMEDIATE CAUSE (a) <b>4/24</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TITLE (SPECIFY) <b>Assistant Medical Examiner</b>	
22c. EXAMINER'S NAME (TYPE OR PRINT) <b>Thomas D. Smith, M.D.</b>		22d. ADDRESS <b>111 Penn Street</b>		22e. DATE <b>1/14/77</b>		22f. SIGNATURE <b>Thomas D. Smith</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>1/16/77</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Tyson Wheeler Funeral Home Rockville, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 20 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Henry McCready</b>		25c. DATE <b>1/14/77</b>	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER MUST WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR RECORDS.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 7 DAYS OF DEATH, THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

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(VR A15 ME (5))  
15M 7/76





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NOV 27 1907  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

TO THE SECRETARY OF AGRICULTURE

RECEIVED  
NOV 27 1907  
U.S. DEPT. OF AGRICULTURE  
WASHINGTON, D.C.

NOV 27 1907



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 77-02315					
1- STATE REGISTRAR												2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edda G. WITTENBERG												2c. DATE ESTIMATED		MONTH DAY YEAR		2d. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
Female		White		June 30, 1907		67 YRS.		MONTHS DAYS HOURS MIN.		1 28 19 77		4:59p		4:59p			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 1003 Caddington Ave.									
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Gershman						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly (Unknown)											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-38-1434				17. INFORMANT Hyman Wittenberg (Same as # 13)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u> 428X } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Myocardial Dis.</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): None																	
19a. DATE OF OPERATION None				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE [Signature]						TITLE (SPECIFY) M.D. Dep						DATE SIGNED Feb 29 1977					
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS, M.D.						ADDRESS 1919 Seminary Road, Silver Spring, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/31/77		23c. NAME OF CEMETERY OR CREMATORY MOUNT LEBANON				23d. LOCATION CITY OR TOWN COUNTY STATE HYATTSVILLE, P. G., MD.							
24. FUNERAL DIRECTOR NAME DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.												25. DATE REC'D. BY REGISTRAR FEB 4 1977		25b. REGISTRAR'S SIGNATURE [Signature]			

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 77-02316

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEWIS NMN WOLFE			2a DATE OF DEATH MONTH DAY YEAR 1 17 77		2b HOUR 5:45 PM
3 SEX male	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR 3 15 83	6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA	7b CITIZEN OF WHAT COUNTRY? American	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.		
10 CITY OR TOWN OF DEATH Tokoma Park	11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Ave. Hosp.		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired blacksmith		12b KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Maryland			13b COUNTY Montgomery		13c CITY OR TOWN Silver Spring
14 FATHER'S NAME FIRST MIDDLE LAST Barney - Wolfe			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Miriam -		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) none		16b SOCIAL SECURITY NO. 579-01-49584	17 INFORMANT ADDRESS Wash. Ave. Hosp. (Records) 1600 Carroll Ave. Tokoma Park Md.		
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic C.V. Disease</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min. 30 min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Fracture Left Hip</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>11/25</u> , 19 <u>76</u> , to <u>1/17</u> , 19 <u>77</u> , that (I) (we) lost saw the deceased alive on <u>1/17/77</u> , 19 <u>77</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.					
22b SIGNATURE <u>Benjamin Isaacson</u>		DEGREE		22c DATE SIGNED <u>1/18/77</u>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>BENJAMIN ISAACSON M.D.</u>		22e ADDRESS <u>7733 ALASKA AVE. NW WASH. DC 20012</u>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 1-19-77		23c NAME OF CEMETERY OR CREMATORY Nat'l. Memorial Park	
23d LOCATION CITY OR TOWN COUNTY STATE Falls Church, Virginia					
24 FUNERAL DIRECTOR NAME Danzansky-Goldberg 1170 Rockville Pike		ADDRESS Rockville, Md.		25a DATE REC'D. BY REGISTRAR JAN 21 1977	
				25b REGISTRAR'S SIGNATURE <u>Patrick McCreedy</u>	

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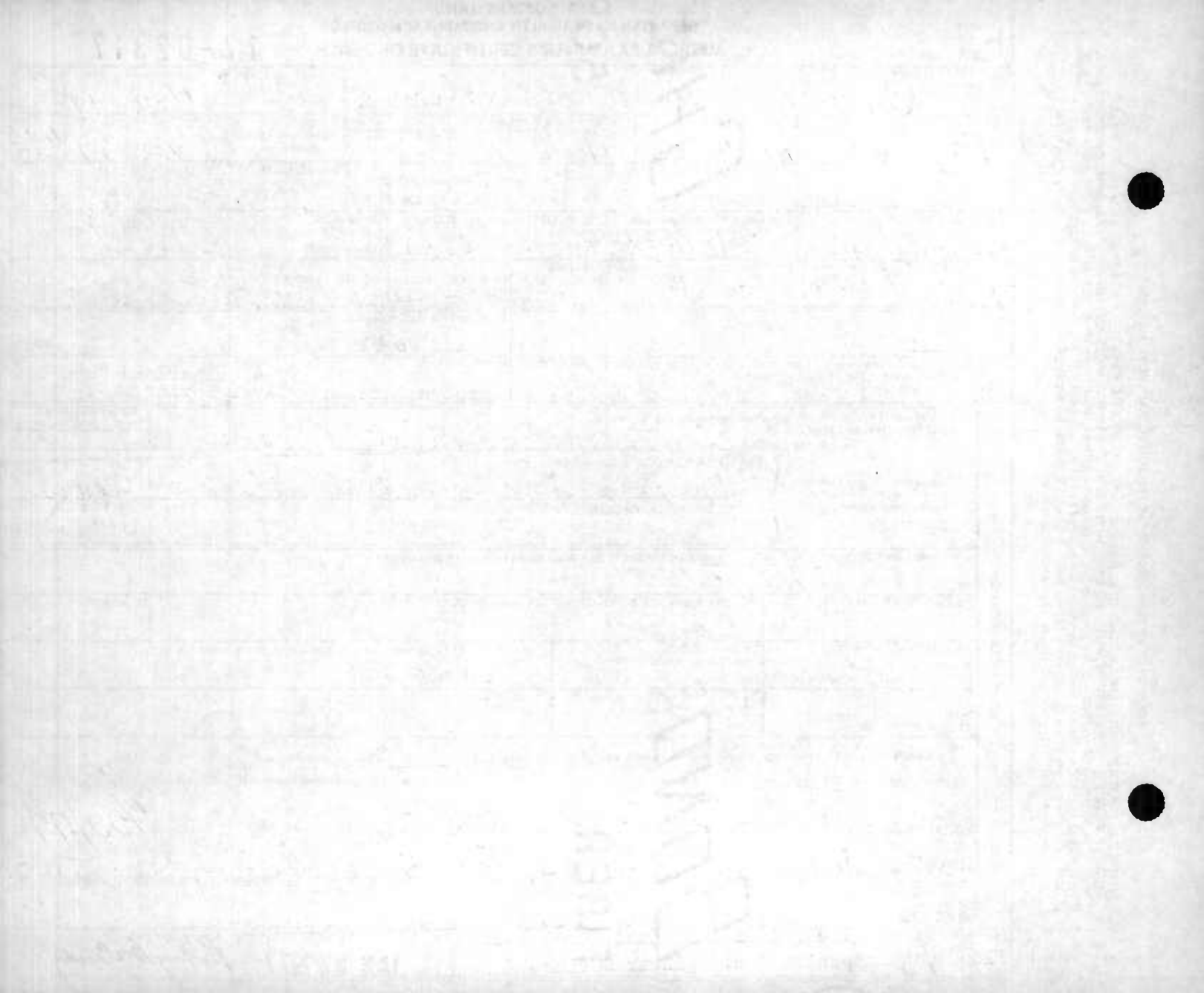
RECEIVED

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 77-02317	
1. DECEASED NAME (TYPE OR PRINT) <i>Virginia King Woodward</i>										2a. DATE OF DEATH KNOWN OF ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <i>1/22 19 77</i>	
3. SEX <i>F.</i> 4. RACE <i>W.</i> 5. DATE OF BIRTH MONTH DAY YEAR <i>12 4 05 71</i> 6. AGE (IN YEARS) LAST BIRTHDAY <i>71</i> 7. IF UNDER 1 YR. MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.										2b. HOUR <i>M</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>North Carolina</i> 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>9904 Sutherland Rd.</i>										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Dental Asst.-Retired</i> 12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>Md.</i> 13b. COUNTY <i>Mont.</i> 13c. CITY OR TOWN <i>Silver Spring</i> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS <i>9904 Sutherland Rd</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>William L. King</i> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Ida Womble</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i> (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO. <i>220-34-8063</i>	
17. INFORMANT <i>Carlyn Bateman</i> ADDRESS <i>9904 Sutherland Road Silver Spring, Md.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic myocardial disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Years</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>None</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>None</i>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>John S. Rogers</i> M.D. TITLE (SPECIFY) <i>Deputy</i> MEDICAL EXAMINER										DATE SIGNED <i>1/22/77</i>	
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN S. ROGERS M.D.</i> ADDRESS <i>Silver Spring Mont. Co.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> 23b. DATE <i>01-25-77</i> 23c. NAME OF CEMETERY OR CREMATORY <i>Ft. Lincoln Cemetery</i> 23d. LOCATION CITY OR TOWN COUNTY <i>Brentwood, Maryland</i>											
24. FUNERAL DIRECTOR <i>Hines/Rinaldi Funeral Home, Inc.</i> ADDRESS <i>11800 New Hampshire Ave., Silver Spring, Md.</i>										25. DATE REC'D. BY REGISTRAR <i>1/27/77</i> 26. REGISTRAR'S SIGNATURE <i>Patrick McCready</i>	





#176, 3d, Film G504 2/2/77 kam

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

77-02318

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Mary</i>			2a. DATE OF DEATH MONTH <i>1</i> DAY <i>7</i> YEAR <i>77</i>			2b. HOUR <i>8:50 pm</i>					
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH <i>1</i> DAY <i>23</i> YEAR <i>98</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS		7. IF UNDER 1 YEAR MONTHS <i>0</i> DAYS <i>0</i>		8. IF UNDER 24 HRS HOURS <i>0</i> MIN <i>0</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Czechoslovakia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.		
10. CITY OR TOWN OF DEATH <i>Bethesda</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Suburban</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>own-home</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> 13b. COUNTY <i>Montgomery</i> 13c. CITY OR TOWN <i>Wheaton</i>						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>12000 Cook Court,</i>		
14. FATHER'S NAME FIRST <i>unknown</i> MIDDLE <i>unknown</i> LAST <i>unknown</i>						15. MOTHER'S MAIDEN NAME FIRST <i>Ann</i> MIDDLE <i>unknown</i> LAST <i>Olexa</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>none</i>			17. INFORMANT ADDRESS <i>Mary Resko-daughter- (same as 13e)</i>					

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>4339</i> (b) <i>generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>myocardial infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE <i>diabetes mellitus with arteriosclerotic heart disease</i>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1) OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <i>Jan 7</i> , 19 <i>77</i> , to <i>Jan 7</i> , 19 <i>77</i> , that (1) (we) lost <i>saw the deceased alive on</i> <i>Jan 7</i> , 19 <i>77</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) <i>view the body after death.</i>									
22b. SIGNATURE <i>W. R. Ehrmantraut MD</i>						DEGREE		22c. DATE SIGNED <i>1/8/77</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W. R. Ehrmantraut</i>						22e. ADDRESS <i>1125 Rockville Pike, Rockville Md</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Jan 11, 1977</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. John the Baptist</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Harpwood Hopwood Penna.</i>	

24. FUNERAL DIRECTOR  
*Warner E. Humphrey, Inc., Clark E. Visor*  
*8434 Ga. Ave., S.S. Md. Clark E. Visor*

25a. DATE REC'D BY REGISTRAR  
*JAN 12 1977*

25b. REGISTRAR'S SIGNATURE  
*Barry McCready*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME 5)  
30M 7/73

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REC'D NO. - 02319	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY YAVENER										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 1 22 19 77 2b. HOUR 7:30 AM											
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-24-1899		6. AGE (IN YEARS) LAST BIRTHDAY 77 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan 22 19 77		2d. HOUR 8:40 AM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Connecticut				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.									
10. CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hotel Manager				12b. KIND OF BUSINESS OR INDUSTRY Retired									
13a. STATE Md.				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Apt. 120 257 Congressional Lane.											
14. FATHER'S NAME FIRST MIDDLE LAST Barnett Yavener						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca Shapiro															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 145-01-6483		17. INFORMANT ADDRESS Route # 2, Box 348, Max Yavener Boonsboro, Maryland 21713															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Vascular Disease -</u> 4124 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT) John B. Ball				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED Jan. 22, 1977									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 1/25/77		23c. NAME OF CEMETERY OR CREMATORY JUDEAN MEMORIAL GARDEN				23d. LOCATION CITY OR TOWN COUNTY STATE OLNEY, MONTGOMERY, MARYLAND											
24. FUNERAL DIRECTOR NAME D.M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.										25a. DATE REC'D. BY REGISTRAR JAN 31 1977		25b. REGISTRAR'S SIGNATURE P. K. McCreedy									

MEDICAL CERTIFICATION

DR. BALL H. STEIN

BP 12



M

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH77-02320  
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) RUTH J. YAZEL			2a DATE OF DEATH MONTH DAY YEAR 1-24-77			2b HOUR 1:05 PM				
3 SEX FEMALE		4 RACE CAUC		5 DATE OF BIRTH MONTH DAY YEAR 8 01 83		6 AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 5 23		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Niantic, Ill		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
10 CITY OR TOWN OF DEATH ROCKVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) COLLINGSWOOD NURSING CTR				12a USUAL OCCUPATION (TYPE WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md. Va.					13b COUNTY Arlington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 613 Walter Reed Dr.	
14 FATHER'S NAME FIRST MIDDLE LAST George William Dingman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Molly Daffenbaugh					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N O			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 548-32-2563		17 INFORMANT ADDRESS Frances J. McKay, Rockville, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Progressive cachexia</i> 4369 } DUE TO, OR AS A CONSEQUENCE OF <i>Stroke - Rheumatic</i> Conditions, if any, which } DUE TO, OR AS A CONSEQUENCE OF <i>Generalized arteriosclerosis</i> gave rise to immediate } cause (a), stating the } underlying cause last } (c) <i>Generalized arteriosclerosis</i>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Saral decubiti, AS HD</i>										
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>10/12</i> 19 <i>76</i> , to <i>1/24</i> 19 <i>77</i> , that (I) (we) last saw the deceased alive on <i>1/24</i> 19 <i>77</i> and that in <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert P. Sisk</i>					22c. DATE SIGNED 1/24/77			22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan 26, 1977		23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Berryville, Clarke Va.			
24. FUNERAL DIRECTOR NAME <i>E. J. Enabes</i>					25a. DATE REC'D. BY REGISTRAR FEB 7 1977					
					25b. REGISTRAR'S SIGNATURE <i>Robert P. Sisk</i>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

05850-31



# CERTIFICATE OF DEATH

77-02321

1. DECEASED-NAME (Type or print) <b>PAULINE NMI ZANNELLI</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>31</b> Year <b>77</b>			2b. HOUR <b>11:35</b> P. M.					
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Oct. 8, 1888</b>		6. AGE (In years last birthday) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Italy</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b>					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wildwood Health Care</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Garrett Pk.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last <b>Unknown</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>213-48-0585</b>			17. INFORMANT Address <b>Salvatore P. Zannelli, Same as 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer Chest</b> <b>4121</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ventricular Fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary Artery Heart Disease</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS CONTRIBUTING <input type="checkbox"/> UNDERLYING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 29, 1978</b> , to <b>Jan 31, 1977</b> , that (I) (we) last saw the deceased alive on <b>Dec 15, 1974</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William H. Killag M.D.</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-1-77</b>			
22d. PHYSICIAN'S NAME (Type) <b>William H. Killag</b>						22e. ADDRESS <b>8218 Wisconsin Ave., Bethesda, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2-3-77</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, Maryland</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 7 1977</b>		25b. REGISTRAR'S SIGNATURE <b>Anthony McCready</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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